DEPARTMENT of HEALTH and HUMAN SERVICES

This is a scanned version of the printed justification document.

Web Version - Part II

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Fiscal Year 2003

Indian Health Service

Justification of Estimates for Appropriations Committees

To obtain a specific section, refer to the IHS Budget website: http://www.ihs.gov/AdminMngrResources/Budget/index.htm

GENERAL STATEMENT

	2001 Actual	2002 Appropriation	2003 Estimate	Increase or Decrease
Current Law BA				
Health Services	$2,264,913,000	$2,388,815,000	$2,452,997,000	+$64,182,000
Facilities	363,103,000	369,487,000	362,571,000	(6,916,000)
Subtotal:	2,628,016,000	2,758,302,000	2,815,568,000	+57,266,000
Accrued Costs 1/	60,992,000	65,814,000	68,575,000	+2,761,000
Proposed Law BA	2,689,008,000	2,824,116,000	2,884,143,000	+60,027,000
Reimbursements				
Current Law	476,301,000	505,685,000	505,885,000	+200,000
Accrued Costs 1/	7,750,000	8,292,000	8,873,000	+581,000
Proposed Law	484,051,000	513,977,000	514,758,000	+781,000
Diabetes 2/	100,000,000	100,000,000	100,000,000	0
Total, Prog.Level:	$3,273,059,000	$3,438,093,000	$3,498,901,000	+$60,808,000
FTE	14,660	14,794	14,877	83

1/ Please see Exhibit S for the crosswalk from current law to proposed law to reflect the Administration's proposal for full accrual retirement and health benefits.

2/ The Balanced Budget Act of 1997 transfers $30,000,000 annually to IHS for diabetes prevention and treatment for FY 1998 through FY 2002, an additional $70,000,000 a year would be drawn from the Treasury out of funds not otherwise appropriated, and in FY 2003 the entire $100,000,000 would be drawn from the Treasury out of funds not otherwise appropriated.

The Indian Health Service program is delivered to a service population of more than 1.5 million American Indians and Alaska Natives through 153 Service Units composed of 568 direct health care delivery facilities, including 49 hospitals, 219 health centers, 7 school health centers, and 293 health stations, satellite clinics, and Alaska village clinics. Within this system, Indian tribes deliver IHS funded services to their own communities with over 44 percent of the IHS budget in 13 hospitals, 161 health centers, 3 school health centers, and 249 health stations and Alaska village clinics. Tribes who have elected to retain the federal administration of their health services or to defer tribal assumption of the IHS program until a later time receive services with about 56 percent of the IHS budget in 36 hospitals, 58 health centers, 4 school health centers, and 44 health stations. The range of services includes traditional inpatient and ambulatory care, and extensive preventive care, including focused efforts toward health promotion and disease prevention activities.

In FY 2003 the following program components will receive funding increases:

- Staffing for newly constructed facilities at Ft. Defiance, Arizona; Parker, Arizona; and Winnebago, Nebraska.
- Construction funding to complete the Ft. Defiance, Arizona, Winnebago, Nebraska, Pawnee, Oklahoma, and St. Paul, Alaska projects; and partially complete the Pinon and Red Mesa, Arizona projects.
- Federal pay costs for civil service, commissioned corps, and tribal

program personnel.

- Contract support costs to support tribal contracting under Public Law 93-638.
- Tribal Epidemiology Centers that serve as critical components of the community-based tribal health programs.
- Implementation of the requirements in the Health Insurance Portability and Accountability Act.
- Contract health services to increase access to care not available in the direct service programs.
- Indian Health Professions to provide collaboration with the Department of Defense and the Veterans Administration on the recruitment of health care professionals.
- Information Technology funding to address critical Departmental infrastructure enhancements of the HHS 5-year plan.

In FY 2003 the administrative and management costs of the IHS Headquarters, Area Offices and service units will be reduced as follows:

- Reduction of administrative and management personnel at all levels through delayering and functional consolidation.
- Control and reduce costs at all levels for travel, leasing, and other administrative related costs.

These specific administrative and management cost reductions and other IHS actions, i.e., workforce planning, restructuring, and increased electronic commerce support the President's Management Agenda and the Secretary's One-HHS goals and objectives while maintaining the special federal-tribal relationship.

United States Government and Indian Nations

The provision of Federal health services to American Indians and Alaska Natives (AI/AN) is based on a special relationship between Indian tribes and the United States provided by Article I, Clause 8, of the United States Constitution. Numerous treaties, statutes, and court decisions first expounded in the 1830's by the U.S. Supreme Court under Chief Justice John Marshall have reconfirmed this relationship. Principal among these is the Snyder Act (25 U.S.C.) of 1921 that provides the basic authority for most health services provided by the Federal Government to AI/AN.

In order to develop stronger partnership between the government and tribal governments, the Department of Health and Human Services and IHS have conducted regional meetings with tribes on an annual basis since 1995. The meetings fostered new partnerships between the government, state, and tribes to meet the health needs of Indian people.

The Indian Health Service and Its Partnership with Tribes

For more than 120 years, the responsibility of AI/AN health care passed among different government branches. In 1955, the responsibility for providing health care to AI/AN was officially transferred to the Public Health Service (PHS).

In the 1970's, federal Indian policy was re-evaluated by the Nixon Administration, and the Indian self-determination policy was adopted. This policy emphasizes tribal administration of Federal Indian programs, including health care. Self-Determination does not lessen any federal treaty obligation, but provides an opportunity for tribes to assume the

responsibility of providing health care for their members.

The Indian Self-Determination and Education Assistance Act of 1975, as amended, and the Indian Health Care Improvement Act of 1976, as amended, gave new opportunities and responsibilities to the IHS and tribes in delivering care. These included specific authorizations for providing health care services to Indian urban populations, an Indian health professions program, and the ability to collect from Medicare/Medicaid and other third party insurers. Under the Indian Self-Determination Act, many tribes have assumed the administrative and program direction roles that were previously carried out by the Federal government. Tribes through Self-Determination contracts or Self-Governance compacts administer over one-half of IHS resources. IHS facilities and providers for the direct provision of services to AI/AN utilize the remaining resources where tribes have elected not to contract or compact their health program at this time, and to purchase care from private health care providers and facilities.

To continue strengthening the federal-tribal partnership, IHS implemented a new budget formulation procedure beginning with FY 1999 integrating the Government Performance and Results Act (GPRA), Public Law 93-638, and annual budget formulation into an iterative process that gives local I/T/U more opportunities for annual budget policy input and review. This process was continued in developing the FY 2003 budget request. Work sessions in all 12 Areas initiated the FY 2003 formulation process and established the health priorities with associated budget priorities on which the FY 2003 budget is based.

The Mission, Goal, and Vision

The mission of the agency is to raise the physical, mental, social, and spiritual health of AI/AN to the highest level, in partnership with the population served.

The Director of the IHS has articulated a vision for the Agency on an annual basis. The IHS vision is to continue to be the best primary care, rural health system in the world. A system that, with tribes, continues its goal of assuring that comprehensive, culturally acceptable personal and public health services are available and accessible to the service population. To reach its goal, the clinical program is made up of many separate activities including maternal and child health; fetal alcohol syndrome; diabetes; alcoholism; mental health; emergency medical services; community health representatives; hepatitis B; dental services; and many others. These programs possess curative and preventive components to a degree unparalleled in any similar program. In addition to these clinically based programs, the Agency also encourages a community based environmental health program, sanitation facilities construction program and health facilities construction program.

In addition, various health care and referral services are provided to Indian people in off-reservation settings through 34 urban programs. Another integral part of the program is the purchase of services from non-IHS providers to support, or in some cases in lieu of, direct care facilities. This Contract Health Services program represents approximately 17 percent of the IHS Budget. The IHS Fiscal Intermediary in FY 2000 processed claims at a total billed amount of $434.5 million. The total paid amount after contract and alternate resource savings was $181 million.

Service Units

Service Units, local administrative units, serve a defined geographic area

and are usually centered on a single federal reservation in the continental United States, or a population concentration in Alaska. Within these 153 administrative units, health care is delivered through 219 health centers, 7 school health centers, 123 health stations, 170 Alaska village clinics, and 49 hospitals by tribally and federally operated Indian health programs.

Area Offices

Twelve Area Offices provide resource distribution, program monitoring and evaluation activities, and technical support to all operations whether IHS direct or tribally operated. They serve to support the Service Units and their points of service delivery.

Headquarters

The Headquarters operations are determined by statutes and administrative requirements set forth by the Department of Health and Human Services, the Administration, the Congress, and field operations (Area Offices and Service Units). Headquarters is involved with the Department in formulating and implementing national health care priorities, goals, and objectives. It is involved with the Administration through the Department in budget and legislative formulation, responding to congressional inquiries, and appropriate interaction with other governmental entities. It provides Area Offices and Service Units with general program oversight and direction, policy formulation, and resource distribution. It provides expert technical expertise, maintains national statistics and project trends and needs for the future.

ACCOMPLISHMENTS

Since its inception in 1955, the IHS has demonstrated the ability to effectively utilize available resources to improve the health status of the AI/AN people. During the past 10 years (1986-1988 to 1996-1998), dramatic improvements in mortality rates were realized including:

- Infant mortality reduced 30 percent
- Accidental deaths reduced 10 percent
- Homicide deaths reduced 16 percent
- Maternal mortality reduced 20 percent
- TB mortality rate reduced 53 percent

It is indeed discouraging that recent mortality data (CYs 1996-1998) available from the National Center for Health Statistics show a small upward trend in the deaths of AI/AN people since CYs 1994-1996 from cancer (all), lung cancer, heart disease, and suicide.

During the past 5 years major strides have been made in reducing traumatic injury among American Indians through the implementation of a broad array of public health measures. These measures include injury surveillance; extensive training for community health practitioners, board-based community coalitions and implementation targeted interventions. A recent analysis of injury deaths indicates a significant downward trend in unintentional injury mortality. For instance, the Navajo Nation motor vehicle deaths have been reduced by almost 40 percent. The IHS Injury Prevention Program Plan describes the necessity of building basic tribal capacity in order to institutionalize change. Injury Prevention is one of the Agency's key health initiatives. Since 1997, IHS has fostered the development of tribal injury prevention programs toward identifying community-specific injury

patterns and in implementing targeted injury intervention projects. Annually, more than 300 tribal health and IHS personnel are trained in injury prevention practitioner skills. These people are working in their communities to reduce the incidence of severe injury and death. Although significant progress has been made, much more could be done to reduce the major burden on the health and well being of Indian communities. Even today, many reservations experience injury death and disability at rates 2-5 times higher than other Americans do. The right programs are in place and this successful model could be expanded to other tribes.

In fulfillment of the federal policy to afford Indian tribes the right to control the health care programs serving AI/AN, IHS and Indian tribes negotiated 48 self-governance compacts and 67 annual funding agreements, which will transfer approximately $642 million to 217 tribes in Alaska and 49 tribal governments in the lower 48 States under the Self-Governance Demonstration Project in FY 2001.

The IHS, through a sub-contract, completed an evaluation of four tribal demonstration programs. These sites were authorized under the Indian Health Care Improvement Act to directly bill and collect for Medicaid and Medicare services. Because of the high degree of success, the 106th Congress enacted permanent authority to allow all tribal programs to implement direct billing and collection.

Work on determining an acceptable methodology for measuring health needs of tribes and Indian people was completed in FY 2000 in fulfillment of Congressional direction to IHS. A national tribal work group guided an economic analysis based on actuarial modeling by a health economics firm. Additional technical support was provided by Agency for Health Care Policy and Research staff and IHS staff. The successful conclusion of this project provides the tribal and federal Indian health policy makers with a method of estimating the benefits and costs of the personal medical services for the American Indian population in comparison to a mainstream health benefit package available through the Federal Employees Health Benefit Program (FEHBP). This method known as the FEHBP Disparity Index (FDI) actually measures equivalence and/or disparity of IHS programs with the FEHBP.

The IHS successfully conducted extensive consultation with Indian tribes on the distribution of $80 million in new funding appropriated for Contract Health Services and the Indian Health Care Improvement Fund in FY 2001. Final agency decisions on the distribution of these new program funds will occur by the end of March 2001 and allotment of funds to each of the 12 areas will take place in April 2001. Another $30 million in new Alcohol and Substance Abuse funding will be targeted to prevention activities at the village level in Alaska Area, and, in the other 11 IHS areas, to address data improvement along with the youth and women acute treatment.

In 2002 and 2003, the IHS will continue to focus on strengthening business office management practices including provider documentation training, procedural coding, processing claims and information systems improvements. In FY 2001 and FY 2002, IHS wide efforts to improve each hospital's capability to identify patients who are eligible or may become eligible for third party reimbursement continued. A major part of this initiative includes the identification of all children who may be eligible for participation in the Children's Health Insurance Program (CHIP). For 2002 and 2003, the IHS will continue working with Center for Medicare and Medicaid Services and the State Medicaid Offices to help ensure the success of this effort.

Special Concerns

Within the vast IHS program, there are certain categories of health conditions that are of special concern in FY 2003. Specific disease entities identified as priority areas by the I/T/U and responsible for much of the health disparities in health status for AI/AN population are targeted by the proposed budget request through the Contract Health Services, Urban Health, Indian Health Profession, and Health Care Facilities Construction. These include mental health, alcoholism, heart disease, maternal child health, and cancers. Investments in public health infrastructure for Pay Costs and Staffing for New Facilities, as well as in information technology for basic systems improvement and privacy act compliance are also included in the request. The Agency budget supports priority activities designed to maintain the capacity to address the top health concerns identified by the Indian tribes and serve the needs of the most vulnerable segments of the AI/AN population including: children, women and elders.

Health care facilities construction is another priority essential to assuring further progress in improving the capacity to provide access to basic primary health care services and raise health status.

ACTIVITY/MECHANISM BUDGET SUMMARY
Department of Health and Human Services
Indian Health Service - 75-0390-0-1-551
Clinical Services

Program Authorization:

Program authorized by 25 U.S.C. 13, Snyder Act, and P.L. 83-568, Transfer Act 42 U.S.C. 2001.

	2001 Actual	2002 Appropriation	2003 Estimate	Increase Or Decrease
Current Law BA	$1,796,236,000	$1,891,939,000	$1,945,125,000	+$53,186,000
Accrued Cost 1/	43,714,000	47,297,000	49,352,000	+2,055,000
Proposed Law BA	$1,839,950,000	$1,939,236,000	$1,994,477,000	+$55,241,000
HIV/AIDS	($3,275,000)	($3,351,000)	($3,415,000)	(+$64,000)
FTE	7,882	7,998	8,101	+103
HIV/AIDS	(14)	(14)	(14)	(0)

1/ Please see Exhibit S for the crosswalk from current law to proposed law to reflect the Administration's proposal for full accrued retirement and health benefits.

Total Request Level -- The Total Request of $1,994,477,000 (including accrued costs of $49,352,000) and 8,101 FTE is an increase of $55,241,000 and 103 FTE over the FY 2002 enacted level of $1,939,236,000 and 7,998 FTE. The explanation of the request is described in the activities that follow.

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HOSPITALS AND HEALTH CLINICS

Indian Health Service

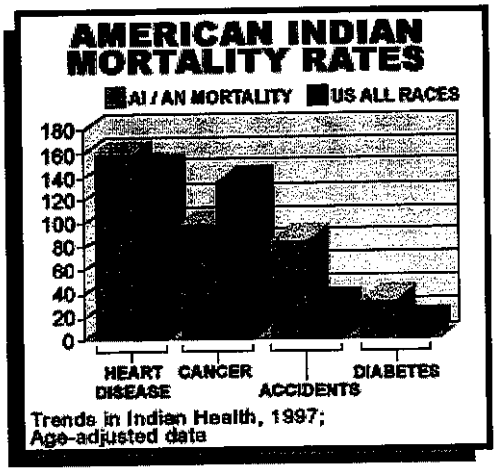
Clinical Services	2001 Actual	2002 Appropriation	2003 Estimate	Increase Or Decrease
Hospitals & Health Clinics				
A. Current Law BA	$1,084,173,000	$1,153,711,000	$1,188,540,000	+$34,829,000
B. Accrued costs 1/	36,996,000	39,993,000	41,607,000	+1,614,000
C. Proposed Law BA	$1,121,169,000	$1,193,704,000	$1,230,147,000	+$36,443,000
D. (HIV/AIDS)	($2,484,000)	($2,531,000)	($2,567,000)	(+36,000)
E. FTE	6,687	6,781	6,840	+59
F. (HIV/AIDS).....	(14)	(14)	(14)	
G. Activity:				
Inpatient: # of Days.....	273,000	273,000	273,000	0
Outpatient: # of Visits: Hospitals....	3,832,000	3,832,000	3,858,000	+26,000
Free-Standing Clinic Visits	3,924,500	3,924,500	3,952,000	+27,500
Total, Visits	7,757,000	7,757,000	7,810,000	+53,500

1/ Please see Exhibit S for the crosswalk from current law to proposed law to reflect the Administration's proposal for full accrued retirement and health benefits.

PURPOSE AND METHOD OF OPERATION

Mission Driven Program

The Hospitals and Health Clinics budget provides funding for health care essential to American Indians and Alaska Natives (AI/AN) and critical to the IHS mission. The mission of the agency is to elevate the health status of its service population to the highest possible level and eliminate disparities in health between AI/AN and the general U.S. population. Since there are significant disparities in the health of AI/AN, this mission is quite challenging.



This element of the budget supports a full range of clinical, preventive, and rehabilitative services and is pivotal to realizing improved health for AI/AN. As will be described below, while the programs provide high quality services in a cost effective manner, the full range of services is not uniformly available to all Indian communities. This budget request includes targeted increases for this budget activity.

Scope of Services in Isolated Communities is Comprehensive

The Hospitals and Health Clinics budget supports essential personal health services including inpatient care, routine and emergency ambulatory care, and medical support services including laboratory, pharmacy, nutrition, health education, medical records, physical therapy, nursing, etc. These services are generally unavailable from any other sources in the communities served through IHS. In addition, the program includes public health initiatives targeting special health conditions that disproportionately affect AI/AN such as specialized programs for diabetes, maternal and child health, youth services, communicable diseases, including AIDS, tuberculosis, and hepatitis, and a continuing emphasis on women's and elder health and disease surveillance.

Other clinical services, e.g., dentistry and community services (e.g., public health nursing, emergency medical services, and community health representatives) along with a number of health programs operated by the tribes (e.g., the USDA nutrition program for women, infants, and children), and behavioral health services (alcohol, substance abuse, and mental health services) are often housed in the same facilities. This co-location of services in the hospital and clinic increases access and promotes a comprehensive community-oriented program that maximizes the synergistic use of human and capital resources. This also facilitates measurement of outcomes around common goals.

Achieve Quality and Customer Satisfaction

The Hospitals and Health Clinics budget provides annual operating expenses for over 500 health care facilities providing in-patient, routine and emergency ambulatory care, and support services. The IHS and tribal staff of these facilities are committed to delivering the highest quality care possible with available resource. The effect of this commitment is reflected in the continuing success in achieving and maintaining Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accreditation of IHS and tribal-operated facilities. The JCAHO, the Accreditation Association of Ambulatory Health Care (AAAHC), and the Health Care Financing Administration (HCFA) regularly and periodically conduct in-depth reviews of the quality of care provided. These accrediting bodies also review the status and safety of the facilities, adequacy and competency of staffing, and management of the service delivery components of the IHS.

All 49 of the IHS funded hospitals are JCAHO accredited and 85 percent of the health centers and clinics have achieved accreditation (some are too small to qualify for accreditation). By comparison, less than 50 percent of non-IHS rural hospitals are JCAHO accredited.

These reviews are based upon the concept of continuous quality improvement in clinical programs utilizing specific performance measures to assess quality of care. The IHS and the tribes fully embrace this concept and services are provided and evaluated using the industry benchmarks for customer satisfaction. The average IHS and tribal hospital accreditation grid score has consistently been at or above the average score for all

U.S. hospitals (average IHS scores are in the 90's on a scale of 0-100). The most frequently cited area for improvement is the physical plant safety and efficiency. The average age of facilities, which was primarily designed for outpatient care, is greater than 30 years. Limited increases in funding will make it difficult to maintain this high standard.

In addition to outside review, the IHS and tribes have developed a number of performance measures to assure or improve quality of care and patient satisfaction.
The following performance indicators are included in the IHS FY 2003 Annual Performance Plan.

Performance Measures Demonstrate Effectiveness

This review process requires that the staffs of the health facility establish performance indicators and demonstrate routine monitoring, analysis, and intervention where the desired outcome is not achieved. Accreditation of individual facilities is based on appropriately established objectives and meeting these standards. Outcome measures monitored by clinical facilities include clinical programs effectiveness such as obstetrics and childcare, management of acute cardiac events, and emergency situation response.

Service appropriateness is measured in a variety of ways. For example, peripartum care is assessed through such measures as: live births successfully managed; neonate Apgar scores (an objective measure of the infant's health at the end of labor and delivery); maternal morbidity measures such as preventable vaginal lacerations, etc.; and the hospital course of the mother and child as measured by morbidity and treatments utilized during the hospital stay. These many measures of peripartum care can be aggregately summarized with one indicator: neonatal mortality. The neonatal mortality rate among AI/AN children in the IHS service population is in fact better than the general U.S. population by 10 percent. Effective outreach activities and accessible clinical service have resulted in a relatively low percentage of low birth weight deliveries and its associated increased infant morbidity and adverse outcomes. The IHS service population rate of low birth weight deliveries is 20 percent below the rate of low birth weight deliveries in the general U.S. population.

> The neonatal mortality rate among AI/AN children in the IHS service population is better than the general U.S. population by 10 percent.

The annual diabetes care audit is another example of monitoring and assessment. Designed to monitor services provided to over 80,000 diabetics, this audit reviews a wide range of performance measures including foot care, eye care, end organ status, and adequacy of blood sugar control. The various measures developed by IHS for this audit are now incorporated into the National Council on Quality Assurance/American Diabetes Association proposal for national performance benchmarks for

diabetes care. IHS performance against these standards has been exemplary by achieving or exceeding the proposed goals for each element.

Recently the managed care industry and state governments have proposed and measured HMO performance against a variety of performance measures contained in the HEDIS (Health Plan Employer Data and Information Set) data set. When compared to HMO performance in the broader population, the IHS-funded programs are at the very top in most measures. For example, the HEDIS data set establishes age specific immunization rates for children served under an HMO (or other managed care plan) similar to the HHS Healthy People 2000 goals.

> A survey of Maryland HMO's (including Kaiser, Aetna and 13 other HMO's) found the average immunization rate to be 67 percent. The IHS average for the same goal was 89 percent during the same time period.

Similarly, the Maryland study also revealed that HMO's achieved screening goals for eye exams on diabetic patients at a rate of 40 percent of the target expectation. The IHS conducts eye exams on greater than 55 percent of its diabetic patients utilizing the same target goal.

Some other IHS outreach and prevention program effectiveness measures are not normally measured by private industry making head to head comparisons difficult to make. For instance, IHS funded nutrition education services uses service provision location to assess penetration of education into the population. More than 30 percent of these activities occur in a community setting in IHS funded programs. IHS believes that these services are crucial for prevention and control yet there is no industry benchmark for comparison. Performance successes assessed through many other health indicators are documented annually in the Agency publications, Trends in Indian Health, and the Regional Differences in Indian Health. These examples indicate that clinical and prevention efforts continuously measure quality through routinely documented, collected, and analyzed data and also highlight the areas where disparities exist.

Training Crucial

This commitment to quality requires regular and specialized training to assure continued success. Thus, the Hospitals and Health Clinics budget activity supports continuing medical education for a wide variety of the health professionals employed by the IHS and tribes. This includes specialized training in quality assurance and case management as well as discipline-specific training. The FY 2002 budget provided some advanced and specialized training for nurses in intensive care unit and operating room skills, nursing management, and the upgrading of Indian individuals from licensed practical nursing to registered nursing. The budget enabled IHS to support quality assurance training through JCAHO, residency training for IHS physicians, residency training for pharmacists, and continuing education of mid-level providers (physician assistants, nurse practitioners, and pharmacy practitioners). These activities are continued in FY 2003.

Managed Care at Work

The Hospitals and Health Clinics activities are enhanced through a managed care process predicated on strategies for providing

- The highest volume of quality services within their appropriation.
- And a rational plan for cost recovery and cost avoidance.

One key aspect in demonstrating the success of this approach is the increasing volume of third party recovery by IHS and tribal facilities (cost recovery). The volume of third party recovery increased by 108 percent between 1995 and 2000. The elimination of unnecessary costs through negotiated rates for purchased services and medical products has also assisted in cost avoidance efforts. To manage growing pharmaceutical costs, IHS uses limited formularies in the service sites, bulk purchasing agreements, and other cost containment approaches.

Through prudent and efficient delivery of care, the IHS provides comprehensive services described above for $1,600 per person per year, a cost of more than 50 percent below that of health insurance for Federal employees.

The IHS provides the comprehensive services described above for $1,600 per person per year, a cost of more than 50 percent below that of health insurance for Federal employees. (Federal employees are funded at over approximately $3,200 per person per year. See IHS LNF Report). The IHS not only manages care through its quality assurance program, but it manages costs effectively as well.

Community Oriented Primary Care Attacks Changing Disease

The IHS program continues to focus on increasing access to preventive and curative services for the underserved in Indian communities. This is ordinarily dealt with by targeting clinical, preventive, and restorative care to communities. The IHS funded programs utilize a strategy of targeted health programming based on community health status to try and provide the most useful services to the most people.

The event leading to death or morbidity appears to be acute, but the factors leading to the illness are chronic in nature.

In recent years the diseases affecting AI/AN have changed and required a change in service focus. The AI/AN disease burden due to acute illness is decreasing while the chronic disease burden is increasing. Significant behavioral determinants often accompany chronic disease. Of particular concern are disease patterns that disrupt families and communities including accidents, suicides, homicides, family violence and chemical dependency. Prevention of these conditions requires a different set of

precepts and disciplines, as they are less susceptible to traditional medical model interventions. These prevention strategies are often difficult to maintain since the impact of the programs is often distant in time and community attention to these efforts may wane in the face of more immediate concerns (such as treatment for trauma associated with family violence).

Promising new developments include community-based wellness centers, school and community based-adolescent clinics and community-based health screening services and these give energy to continued investment in such less immediately gratifying efforts. In one case, Zuni, NM, published data in *MMWR, Runner's World, Diabetes Care,* and *Public Health Reports,* suggesting that the use of the community wellness center reduced dependence on medication among diabetics and that participants required fewer medical visits than those who did not access the wellness center.

This emphasis on community-oriented primary care is particularly well suited to the unique health needs of AI/AN people. The impressive accomplishments of the IHS have resulted from the broad community approach employing public health nurses (PHNs), alcoholism workers, mental health workers, and sanitarians in partnership with the medical/clinical staff. These skills more directly address the community effects of higher unemployment, lower socioeconomic status, and the complications of poor nutrition, sanitation, and housing found in many AI/AN communities.

Maintaining progress made

The progress made utilizing this strategic approach requires maintenance and continued efforts. This budget proposes to increase funding to allow for maintenance (in the face of increased resource and supply cost, increased population, and utilization).

ACCOMPLISHMENTS

The agency made significant progress in addressing chronic diseases. The primary focus has been in treatment and prevention of diabetes. The increases provided have allowed greater access to the most sophisticated interventions available. This includes more effective pharmaceuticals, more aggressive screening for the secondary effects of diabetes, earlier intervention when complications are identified, and greater patient compliance with care regiments.

Additional funding was provided for podiatric services in FY 2001. The funds have allowed the addition of a number of podiatrists to provide services at the community level. The most important impact of these funds however was to raise the awareness of all providers of the importance of screening, prevention, and early intervention in changes associated with diabetes. In FY 2001, IHS staff also published material documenting the effectiveness of these strategies in reducing amputations in AI/AN populations. These strategies are being actively disseminated as standards of care for prevention and treatment of diabetic complications.

The agency has examined the underlying causes and risk factors contributing to the development of diabetes and heart disease. Of particular interest is a report provided to Congress exploring the scope and impact of obesity as a risk factor in the development of chronic disease. This report noted that obesity is three times more frequent

among AI/AN children and this disparity persists into adult life. This high rate of obesity clearly contributes to the development of diabetes and heart disease. The report also provided information on promising interventions that may reduce the risk for chronic disease. Some are as simple as the promotion of breast-feeding in infancy and others involve wider community commitment to dietary and exercise interventions. The agency is examining means to disseminate these interventions on a wider basis. The agency has entered into a partnership with the National Heart, Blood, and Lung Institute in three communities to demonstrate the efficacy of community based interventions.

Other promising partnerships with NIH entities have emerged. Of significance was the funding of Native American Research Centers in Health (NARCH). This program developed in partnership with the National Institute of General Medical Studies (NIGMS) will provide support for tribally controlled research centers to focus on the diseases disparately affecting American Indian and Alaska Native people. It has the added advantage of developing AI/AN researchers who will focus on the communities from which they come. This will help assure that the most scientific understanding of the impact of disease in this unique population is explored and disseminated.

Promising partnerships were also developed with the Centers for Disease Control and Prevention. Of particular significance in this partnership is the enhancement of a variety of public health capabilities serving AI/AN communities. For example, a strong partnership with the CDC diabetes activities is designed to assure that best practices in diabetes management are identified and disseminated using the joint resources of the CDC Diabetes Translation and Dissemination Program and the IHS Diabetes Program. Another example is the partnership aimed at surveillance and prevention of Hepatitis C. This critical effort is needed since the rates of Hepatitis C appear to be higher in AI/AN populations and it is a preventable disease. Another effort supported by the collaborative activities between CDC and IHS is support for the developing tribal epidemiology centers. This public health capacity is vital to informing tribal leadership and other policy makers about the specifics of health needs and efficacious interventions. It has increased the tribal capacity to exercise the public health functions of government. The agency has also taken great strides in addressing pharmacy. This includes analysis of the factors leading to the steep rise in pharmaceutical costs and the implementation of some interventions to assume greater control of these costs. The interventions initiated or enhanced to control costs include greater use of bulk purchasing methods, increased use of a limited but more efficacious formulary, and education of providers about specific pharmacoeconomic strategies. This effort was enhanced by the provision of resources for expansion of the IHS pharmacy residency activities. The residency programs now operate in 11 communities and stimulate innovative thinking about the control of pharmaceutical costs and less expensive, but more effective approaches to patient care. Of particular significance is the increase in pharmacist care for such programs as anti-coagulation and cancer chemotherapy management. This provides more in-depth care (under physician supervision) that capitalizes on the unique skills of pharmacists with specialized technical training in these areas.

Emergency services also utilized an increase to improve programs at the community level during FY 2001. The Congress provided funds that assisted

the EMS programs in a variety of communities to assure the stability of staffing and the maintenance of vital equipment. It also stimulated new analysis that was completed in FY 2002 that identifies the EMS needs of IHS and Tribal programs. Many community ambulance services in rural America are struggling to survive (both Indian and non-Indian) and the IHS is looking for creative ways to create partnerships that will strengthen local EMS efforts. IHS has entered into a partnership with the Health Resources and Services Administration (HRSA) to jointly examine these issues.

Lastly, the agency has explored and resolved a number of policy issues with the Center for Medicare and Medicaid Services (CMS). These issues included such matters as eligibility and co-payment concerns in the State Children's Health Insurance Program (SCHIP). These efforts were aimed at assuring the greatest possible utilization of resources available to eligible AI/AN patients for services.

Performance Measures

The FY 2003 funding request for Hospitals and Clinics will contribute to the accomplishment of the performance indicators below. These indicators are sentinel indicators representative of some of the more significant health problems affecting AI/AN.

Indicator 1: During FY 2003, continue tracking (i.e., data collection and analyses) Area age-specific diabetes prevalence rates to identify trends in the age-specific prevalence of diabetes (as a surrogate marker for diabetes incidence) for the AI/AN population.

Indicator 2: During FY 2003, maintain the FY 2002 performance level for glycemic control in the proportion of I/T/U clients with diagnosed diabetes.

Indicator 3: During FY 2003, maintain the FY 2002 performance level for blood pressure control in the proportion of I/T/U clients with diagnosed diabetes who have achieved blood pressure control standards.

Indicator 4: During FY 2003, maintain the FY 2002 performance level for the proportion of I/T/U clients with diagnosed diabetes assessed for dyslipidemia (i.e., LDL cholesterol).

Indicator 5: During FY 2003, maintain the proportion of I/T/U clients with diagnosed diabetes assessed for nephropathy.

Indicator 6: During FY 2003, maintain the proportion of eligible women who have had a Pap screen within the previous three years at the FY 2002 levels.

Indicator 7: During FY 2003, maintain mammography screening at the FY 2002 rate.

Indicator 8: During FY 2003, maintain the proportion of AI/AN children served by IHS receiving a minimum of four well-child visits by 27 months of age at the FY 2002 level.

Indicator 10: During FY 2003, maintain the proportion of I/T/U prenatal clinics utilizing a recognized screening and case management protocol(s)

for pregnant substance abusing women at the FY 2002 level.

Indicator 15: During FY 2003 the IHS will address domestic violence, abuse, and neglect by assuring that:

a. at least 85 percent of I/T/U medical facilities (providing ER and urgent care) will have written policies and procedures for routinely identifying and following:
    a. intimate partner abuse (IPV)
    b. child abuse and/ or neglect
    c. elder abuse and/ or neglect
b. at least 60 percent of I/T/U medical facilities (providing direct patient care) will provide training to the direct clinical staff on the application of these policies and procedures
c. a standard data code set is developed for the screening of intimate partner abuse in conjunction with the Family Violence Prevention Fund and AHRQ

Indicator 16: During FY 2003, the IHS will continue the development of automated approaches for deriving performance information by:

a. Completing collection of baseline data for any performance measures where electronic data collection was implemented in FY 2002 and continue collection into measurement years,
b. Implementing additional electronically derived performance measures as their accuracy is proven to be sufficient,
c. Distributing semi-automated LOINC mapping tool for IHS's clinical information system to all (100%) I/T/U sites; achieve full local LOINC mapping at 5 sites in addition to the 5 pilot sites.

Indicator 19: During FY 2003, maintain 100% accreditation of all IHS hospitals and outpatient clinics.

Indicator 20: During FY 2003, the IHS will:

a. Establish baseline data for medication error reporting for all IHS Areas using an approved instrument and compare this national data with other national benchmarks. (While this will not be a true medication error rate, it will allow IHS to see improvement in reporting if the number of reported errors increases over time).
b. Pilot test, in two areas, a standardized anonymous medication error reporting system.

Indicator 21: By the end of FY 2003, secure baseline consumer satisfaction levels by using an OMB approved instrument.

Indicator 23: In FY 2003, maintain FY 2002 levels in the proportion of AI/AN children who have completed all recommended immunizations for ages 3-27 months, as recommended by Advisory Committee on Immunization Practices.

Indicator 24: During FY 2003, maintain FY 2002 influenza vaccination rates among non-institutionalized adults aged 65 years and older.

Indicator 26: During FY 2003, assure that the unintentional injury-related mortality rate for AI/AN people is no higher than the FY 2002 level.

Indicator 28: During FY 2003, the IHS will continue collaboration with NIH to assist three AI/AN communities to implement culturally sensitive community-directed pilot cardiovascular disease prevention programs and initiate expansion into at least one new AI/AN site.

Indicator 29: During FY 2003, begin implementation or continue implementation all components of the Indian health system obesity prevention and treatment plan developed in FY 2002 that include:

- a multidisciplinary stakeholder obesity prevention and treatment planning group
- a staff development and IT development plan to assure securing height and weight data for all system users to monitor AI/AN population obesity
- an infrastructure to collect, interpret and diffuse the approaches from obesity related demonstration projects and studies to IHS Areas and I/T/Us

Indicator 31: During FY 2003, maintain ongoing surveillance of HIV/AIDS and establish baselines for completeness of reporting in at least 2 additional Areas.

Indicator 32: During FY 2003, increase the percentage of high risk sexually active persons who have been tested for HIV and received risk reduction counseling at least 5 percent above the FY 2002 level.

Indicator 41: By the end of FY 2003, the IHS will increase by 10 percent over the FY 2002 level the proportion of I/T/Us who have implemented Hospital and Clinic Compliance Plans to assure that claims meet the rules, regulations, and medical necessity guidance for Medicare and Medicaid payment.

Funding for the Hospitals and Health Clinics program during the last five years has been as follows:

Year	Funding	FTE
1998	$906,801,000	8,020
1999	$949,140,000	8,067
2000	$1,005,407,000	6,877
2001	$1,121,202,000	6,687
2002	$1,153,711,000	6,781

RATIONALE FOR BUDGET REQUEST

Total Request -- The request of $1,230,147,000 (including accrued costs of $41,607,000) and 6,840 FTE is an increase of $36,443,000 and 59 FTE over the FY 2002 enacted level of $1,153,711,000 plus accrued cost of $39,993,000 and 6,781 FTE. The increase includes the following:

Pay Cost Increase: +$29,649,000

The provision of funds for pay increases for Federal, tribal and Urban employees are crucial if the system is to retain its employees. The I/T/U

programs have vacancy rates of approximately 22 percent in dental staff and greater than 25 percent in pharmacy staff. An increase of $4.1 million is requested elsewhere in the budget for recruitment of health professionals.

Phasing-In of Staff for New Facilities: +$8,879,000 and 109 FTE

The request of $8,879,000 and 109 FTE provides for the phasing-in of staff and related costs for new facilities. The staffing of new facilities also contributes to the recruitment and retention of medical staff and promotes self-determination activities. The following table displays the requested increase.

Facilities	Dollars	FTE	Tribal
Ft. Defiance, AZ Hospital	$4,478,000	56	0
Parker, AZ Health Center	1,280,000	16	0
Winnebago, NE Health Center	3,121,000	37	2
Total	$8,879,000	109	2

Epidemiology Centers: +$1,500,000

See page 165

Privacy Regulations: +$850,000

The broad scope of the HIPAA regulations has a national and area impact on the IHS. The regulations affect multiple levels of operations within the Agency including the headquarters level, the area level, and all field locations such as service units and clinics. This would include hospitals, health stations and school health centers. The current funding request is to support the privacy standard and selected critical associated security requirements. These actions are required under the medical privacy regulations of HIPAA. These standards are currently being reviewed and will be established as an IHS wide benchmark.

The request of $850,000 will help to provide for the implementation of the privacy standard in the IHS. Currently IHS has through the Privacy Act of 1974 rules as well as the established IHS system of records for health and medical records a system to protect the privacy of patient medical information. HIPAA has changed this process by requiring the implementation of additional standards and rules. Under the HIPAA Medical Privacy rules, one of the standards is that "covered entities" MUST train the workforce and designate a privacy officer who is responsible for ensuring the procedures are followed.

Accrued Retirement and Health Benefits Costs:

The increase of $1,462,000 is associated with the proposed Managerial Flexibility Act of 2001; the full accrued cost in FY 2003 for Hospitals and Health Clinics is $41,607,000. This legislation requires agencies, beginning in FY 2003, to pay the full Government share of the accruing cost of retirement for current CSRS, CIA and Foreign Service employees, and the Coast Guard, Public Health Service and NOAA Commissioned Corps. The legislation also requires agencies to the pay full accruing cost of post-retirement health benefits for current civilian employees. The intention of the legislation is to budget and present the full costs of Federal employees in the accounts and programs where they are employed.

This legislation is part of an initiative to link budget and management decisions to performance by showing the full cost of each year's program operations together with the output produced that year. These accrual costs are shown comparably in FY 2001 and FY 2002.

Administrative/Management Reforms: -$4,435,000 and -50 FTE

The IHS will save $4,436,000 through management improvements, which will result in the savings of 50 FTE and $2,951,000. In addition, we will judiciously control and reduce costs associated with administrative travel, overtime, copying, and the purchase of administrative equipment and supplies. In addition we will place a moratorium on the acquisition of additional administrative office space and carefully control training costs, promoting distance learning and training at the local level whenever applicable.

DENTAL HEALTH

Indian Health Service

Clinical Services Dental Health	2001 Actual	2002 Appropriation	2003 Estimate	Increase Or Decrease
A. Current Law BA	$91,018,000	$95,305,000	$100,085,000	+$4,780,000
B. Accrued costs 1/	4,190,000	4,573,000	4,816,000	+243,000
C. Proposed Law BA	$95,200,000	$99,878,000	$104,901,000	+$5,023,000
D. FTE	749	767	789	+22
E. Patients Treated	328,000	335,000	343,000	+8,000
F. Services Provided	2,487,000	2,509,000	2,536,500	+27,500

1/ Please see Exhibit S for the crosswalk from current law to proposed law to reflect the Administration's proposal for full accrued retirement and health benefits.

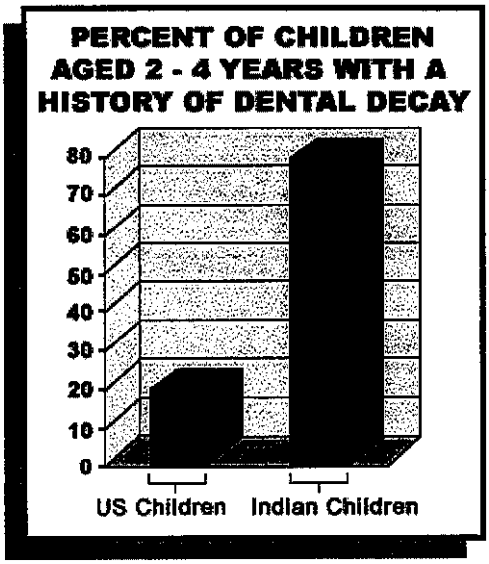
PURPOSE AND METHOD OF OPERATION

Program Mission and Responsibilities

The IHS Dental Program is committed to raising the oral health status of the AI/AN population to the highest possible level through the provision of high quality preventive and treatment services in both the community and clinic levels. Despite a history of documented improvements in oral health status, the oral health of Indian people still lags well behind that of the overall population of the United States; this disparity may be increasing. For the past three years oral health problems have been identified by consumers participating in budget formulation activities among the top priorities for funding enhancement. As a result, oral health has been identified as one of the IHS Director's initiatives.

Between the early 1970s and the early 1990s, a period of overall dental program expansion, the IHS Dental Program made significant strides in improving the oral health of the AI/AN population. Results of the IHS-wide Oral Health Status and Treatment Needs Survey of over 25,000 dental patients completed in 1991 revealed several important findings. When compared with results from earlier monitoring surveys, a general decline in tooth decay among children and adults was detected. This encouraging trend can be attributed mainly to the extensive commitment that the IHS and local communities have made to water fluoridation during the past decade and the expanded use of dental sealants. However, AI/ANs continue to have substantially higher rates of dental caries and periodontal disease than the U.S. population at large.

Indian people are affected by dental disease at rates 2 to 10 times that of the overall U.S. population; for Indian patients with diabetes the disparity is even greater.



A follow-up oral health survey was initiated in FY 1999 to determine the current oral health status and continued or emerging problems that must be addressed. Approximately 13,000 dental patients ranging from 2 to 96 years participated in the survey in all 12 Areas. The findings point to conditions that are continuing to improve such as children's access to preventive dental sealants. However, the data reveal stable or even worsening oral health trends for thousands of AI/AN families. We hope that by recognizing and understanding these trends, tribal leaders, the IHS, and other key stakeholders will be able to develop policies and programs that assure adequate oral health care for all AI/ANs.

Trends in Oral Health Based on Three Surveys of Dental Patients

- Since 1991, there has been a significant increase in tooth decay among young AI/AN children between 2-4 years of age.

- From 1984 to 1991, there was a large decrease in overall decay rates in the permanent teeth of school children. However, from 1991 to 1999, there was a significant increase in the number of teeth with active decay. In other words, the same numbers of teeth are getting cavities, but fewer of those cavities are being filled.

- In adults, there has been a slight decrease in decay rates over the last nine years. In addition, adults are losing fewer teeth to dental disease and trauma. Periodontal disease rates, however, have not changed since the 1991 Oral Health Survey where it was shown that AI/AN people experience higher prevalence and severity of periodontal disease as compared to the all U.S. population.

- More Indian elders are keeping their teeth longer. Since 1984 there has been a continued trend toward fewer elders with no teeth and more elders with 20 or more teeth.

Dental Workforce Issues

Overall the IHS has a relatively low level of funding for dental care compared to the nation as a whole (i.e., 3.5 percent of health expenditures in IHS versus 6 percent for the nation). Thus, the IHS has been faced with the formidable task of reducing the ravages of oral disease at rates at two

to 10 times the national level but with a workforce (i.e., dentist to population ratio) roughly half the national average.

Probably the most compelling evidence that the IHS Dental Program is losing its capacity to serve the AI/AN population is that annual utilization of dental services dropped to approximately 22 percent from a high of 33 percent in the early 1990s.

The dental program continues to face problems in recruitment and retention of dentists due to the lack of parity with the private sector relative to pay and a 33 percent decline in the number of dentists being trained.

Working in partnership with professional organizations, dental schools, and tribes, efforts are being made to remedy this workforce crisis through an aggressive recruitment program. This includes use of loan repayment, scholarships, the internet and media. A request of $5 million in the IHS Indian Health Professions budget to recruit former military health professionals will enhance these efforts. More information on this area is provided beginning on page 121 of this document.

Currently, access to dental care at IHS is below full capacity because of a dental workforce crisis: approximately 22 percent of the dentist positions in the IHS are vacant.

Public Health Infrastructure and Capacity

The IHS has been traditionally oriented toward preventive and basic care. More complex, rehabilitative care, although a legitimate need, is often deferred so the basic services may be provided to more persons. Within the Schedule of Services, service priority hierarchies used by the Dental Program, over 90 percent of services provided are basic and emergency care. Estimates of demand for treatment remain high; however, a continuing emphasis on community health promotion/disease prevention is essential to long-term improvement in the oral health of AI/ANs.

In FY 2000, the IHS developed a process to build public health infrastructure through tribal and IHS partnerships. Four tribal health boards were funded to implement Dental Clinical and Preventive Support Centers. They are Alaska Native Tribal Health Consortium, All Indian Pueblo Council, Inter-tribal Council of Arizona, and Northwest Portland Area Indian Health Board. In FY 2001, three additional awards were made: Confederated Salish and Kootenai Tribes of the Flathead Nation in cooperation with the Billings Area IHS, Oklahoma City Area Inter-Tribal Health Board, and the Aberdeen Area IHS.

Tribal programs continue to exert a growing influence in the management of oral health programs. The number of tribally managed programs continues to grow steadily. Staff employed by or providing care in tribal programs produce over a third of the total direct dental services provided to AI/AN people. To responsibly manage a health program requires data that support an assessment of the health needs of the population. Tribal programs were well represented in the IHS 1991 and 1999 Oral Health Survey of Indian patients. Data gathered by these surveys provide tribes information from which to make rational decisions regarding their dental programs.

Best Practices/Industry Benchmarks

The IHS Dental Program has a long and distinguished history of serving as a benchmark of dental public health excellence. Beginning in the 1960s, the IHS Dental Program was a pioneer in developing dental resource planning methods, and, in the early 1970's, published some of the first and most compelling findings regarding the efficiency and effectiveness of using expanded duty dental assistants in the provision of dental restorations.

Later in the 1970s, the IHS published what still remains as one of the most comprehensive and recognized approaches to quality assurance for dental care. In the 1980s and 1990s, the IHS Dental Program was recognized by winning three U.S. Public Health Service J.D. Lane research competitions for community based research/education projects as well as three American Dental Association awards for health promotion/disease prevention.

The program's Baby Bottle Tooth Decay Prevention Project, which won two of these awards, has been cited internationally as a model of community empowerment and program effectiveness. As part of these activities the IHS Dental Program collaborated with the World Health Organization, the Centers for Disease Control, the National Institutes of Health, the Head Start Bureau, and several universities.

The Early Childhood Caries 5-year demonstration project was evaluated in FY 2001. The goals of this demonstration project are to reduce the percentage of young children with dental decay to 25 percent from baseline at each of the demonstration sites as well as to increase access to dental services by 25 percent at each site. Access to dental care more than doubled over the project period with the number of children 0-3 years who received a dental exam increasing from 738 to 1,599. The number of children 0-3 years who received a fluoride treatment increased 7.7 times. The prevalence of ECC remained constant at all sites except one. This site used a more frequent application of fluoride varnish and also had an intensive educational program for pre-natal mothers as well as for families of young children. Results of the demonstration project have been distributed program-wide.

The ultimate benchmark of success for a public health organization is what it accomplishes in term of positive outcomes for the people it serves. Comparing findings from the 1999 oral health survey with the 1991 survey, analysis shows:

A **14 percent increase** in the number of children 5-19 years with no decay.

A **12 percent decrease** in the number of children 5-19 years with high decay rates (7 or more cavities).

A **21 percent increase** in the number of protective dental sealants placed on first and second molars in adolescent's ages 14 years.

A **9 percent decrease** in the number of adults 35-44 years with periodontal disease (based on CPITN scores).

A **21 percent increase** in the number of adults 35-44 years who have never lost a tooth to periodontal (gum) disease or dental caries (cavities).

ACCOMPLISHMENTS

The IHS dental program at Headquarters has been reorganized as the Division of Oral Health. Currently four professional and one administrative person comprise the staff that support a cadre of over 2500 dentists, dental assistants and hygienists in tribal and direct programs.

Specific accomplishments include:

- A workgroup has developed and is promoting clinical and community-based strategies to reduce the prevalence of early childhood decay. The strategies include providing a dental screening or exam by age one by medical and dental providers, teaching parents to brush their child's teeth and looking for early lesions that can be reversed with fluorides, and educating families about the disease process, diet and the importance of various fluorides.

- To reduce the prevalence of the dental decay, and increase access to care, a work group has developed a medical model of care that addresses dental decay as an infectious disease. Some of the key concepts are the importance of diagnosis of caries, assessing the risk of disease and applying the most appropriate preventive regimens and recall frequencies based on the individual patients needs and demands.

- National Oral Health Council composed of tribal and IHS clinical dental staff has been formed and have an approved charter. This group will provide a field perspective to issues facing the dental program.

- The Division of Oral Health has completed the oral health status and treatment needs survey of approximately 13,000 patients. A report has been completed with data analysis and program recommendations. Tribal and field input was solicited for the report.

- The IHS, National Institutes of Dental and Craniofacial Research, and State University of New York at Buffalo continue to collaborate on the treatment of periodontal disease in persons with diabetes. The initial clinical trial conducted in the Phoenix Area demonstrated the effectiveness of a non-surgical treatment regimen. The project is currently being replicated in the Albuquerque Area. Three 5-year grants were awarded in FY 1998 and three awards were made in FY 2001 to help IHS, tribal, and urban programs incorporate this technology into their dental programs.

- The Division of Oral Health has developed a process for awarding resources to tribes and Areas to help build the public health infrastructure and capacity through dental clinical and preventive support centers. In FY 2000, four tribal programs were awarded resources to demonstrate unique strategies to provide training and technical assistance to programs within their geographic areas. In FY 2001, three additional tribal/Area programs were awarded.

- The Division of Oral Health continues its efforts to support tribal community water fluoridation programs. In its third year of a three-year inter-agency agreement with the Centers for Disease Control and Prevention (CDC), strategies are being developed to support small water systems to effectively maintain optimal levels of fluoride in their water in order to

assure the dental benefits. The Albuquerque and Phoenix Areas are part of the demonstration and have shown a 38 percent increase in water fluoridation compliance from FY 99 to FY 2000.

- Strategies to recruit and retain more dentists in the IHS have been implemented to include an interactive website, promoting civil service Title 38 for dentists, and an expansion of program dollars for loan repayment. A dental recruitment video and pamphlet was developed. The dental program has a contract with the Choctaw Nation to assist in recruiting that will target the private sector dentists that might be interested in seeking alternate practice opportunities within the IHS either as part-time contractors, volunteers and/or locum tenums. The vacancy rate declined from 25 percent to 22 percent during the past fiscal year.

- The Indian Health Service (IHS) Division of Oral Health (DOH) and the National Institutes of Health/National Institute of Dental and Craniofacial Research (NIH/NIDCR) signed a Memorandum of Understanding MOU) on July 13, 2001. The MOU was developed in order to facilitate collaborative activities between the NIDCR and the DOH aimed at improving the oral health of American Indian and Alaska Native people.

- The "Dental Services for American Indians and Alaska Natives, 1990 - 2000" was published and distributed widely to IHS programs and tribal leaders. Copies are available through the Division of Oral Health.

PERFORMANCE MEASURES

The following performance indicators are included in the IHS FY 2003 Annual Performance Plan. These indicators are sentinel indicators representative of some of the more significant health problems affecting AI/AN. At the FY 2003 funding level, IHS would be able to achieve the following:

Indicator 11: During FY 2003, increase the proportion of AI/AN population receiving optimally fluoridated water by 5 percent over the FY 2002 levels for all IHS Areas.

Indicator 12: During FY 2003, maintain the proportion of the AI/AN population that obtain access to dental services at the FY 2002 level.

Indicator 13: During FY 2003, maintain the number of sealants placed per year in AI/AN children at the FY 2002 level.

Indicator 14: During FY 2003, increase the proportion of the AI/AN population diagnosed with diabetes who obtain access to dental services by 2 percent over the FY 2002 level.

Funding for the Dental Health program during the last five years has been as follows:

Year	Funding	FTE
1998	$65,517,000	818
1999	$71,400,000	763
2000	$80,062,000	745
2001	$95,200,000	749
2002	$99,878,000	767

RATIONALE FOR BUDGET REQUEST

TOTAL REQUEST -- The request of $104,901,000 (including accrued costs of $4,816,000) and 789 FTE is an increase of $5,023,000 and 22 FTE over the FY 2002 enacted level of $95,305,000 plus accrued cost of $4,573,000 and 767 FTE. The increases are as follows:

Pay Cost Increases: +$3,166,000

The request of $3,166,000 for federal/tribal/urban (I/T/U) pay costs would fund in part the increases associated with on-going operations.

The IHS continues to strive to increase access for the IHS patient population. Maintaining the current I/T/U health system is necessary in eliminating disparities in health status between AI/AN and the rest of the U.S. population.

Phasing-In of Staff for New Facilities: +$1,857,000 and 22 FTE

The request of $1,857,000 and 22 FTE provides for the phasing-in of staff and related costs for new facilities. The staffing of new facilities also contributes to the recruitment and retention of dental staff and promotes self-determination activities.

The following table displays the requested increase.

Facilities	Dollars	FTE
Ft. Defiance, AZ Hospital	$1,349,000	16
Parker, AZ Health Center	254,000	3
Winnebago, NE Hospital	254,000	3
Total	$1,857,000	22

Accrued Retirement and Health Benefits Costs

The increase of $243,000 is associated with the proposed Managerial Flexibility Act of 2001; **the full accrued cost in FY 2003 for Dental Health is $4,816,000.** This legislation requires agencies, beginning in FY 2003, to pay the full Government share of the accruing cost of retirement for current CSRS, CIA and Foreign Service employees, and the Coast Guard, Public Health Service and NOAA Commissioned Corps. The legislation also requires agencies to the pay full accruing cost of post-retirement health benefits for current civilian employees. The intention of the legislation is to budget and present the full costs of Federal employees in the accounts and programs where they are employed. This legislation is part of an initiative to link budget and management decisions to performance by showing the full cost of each year's program operations together with the output produced that year. These accrual costs are shown comparably in FY 2001 and FY 2002.

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MENTAL HEALTH SERVICES

Indian Health Service

Clinical Services

Mental Health	2001 Actual	2002 Appropriation	2003 Estimate	Increase or Decrease
A. Current Law BA	$45,018,000	$47,142,000	$50,626,000	+$3,484,000
B. Accrued Costs 1/	1,561,000	1,700,000	1,873,000	+173,000
C. Proposed Law BA	$46,579,000	$48,842,000	$52,499,000	+$3,657,000
D. FTE	279	285	307	+22
E. Client Contacts	208,000	208,000	208,000	0

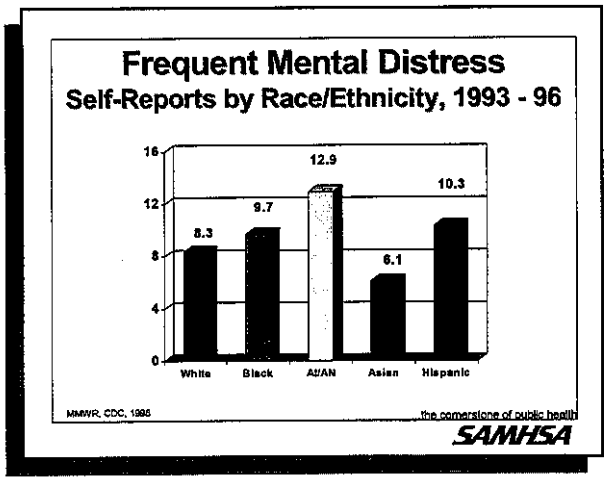
1/ Please see Exhibit S for the crosswalk from current law to proposed law to reflect the Administration's proposal for full accrued retirement and health benefits.

PURPOSE AND METHOD OF OPERATION

PROGRAM MISSION AND RESPONSIBILITIES

The IHS Mental Health and Social Services (MH & SS) program is a community oriented clinical and preventive service program. The MH & SS services provided are a part of a larger Behavioral Health Program that includes the Alcoholism and Substance Abuse Program. This programmatic collaboration was established as a response to the identified needs of IHS, Tribes, and Urban Programs (I/T/U). Field staff report serious mental and social problems in many AI/AN communities on reservations and in urban settings. Four of the top ten health issues identified by the I/T/Us include issues pertinent to behavioral health are suicide, domestic violence, child abuse and neglect, and alcohol and substance abuse disorders. American Indian and Alaska Native (AI/AN) communities possess considerable traditional and cultural resources; however, the level of psychosocial and emotional distress remains alarmingly high. Improvements in physical health status for AI/AN populations have not been paralleled in the mental health and social services arena.

Mental health and social services disparities will be maintained or possibly widened as client contacts decrease due to limited funds and position vacancies.



Health Clinic staff indicate that mental health and social problems are associated with more than one-third of the demands made on health facilities for services. Depression, anxiety, and post-traumatic stress disorder are emotional problems that are reported frequently in IHS patient care data. Corroborating data from the Substance Abuse and Mental Health Services Administration (SAMHSA) depicted in the adjacent graph demonstrates that AI/AN have the highest rates of mental distress of all ethnic and racial groups. These data included point to the potential significant

cultural, social, and economic impact of mental health on AI/AN people.

Providing care for AI/AN with disabilities demands special attention. A report prepared by the Native American Committee of the Task Force on Employment of Adults with Disabilities (2000), indicates that more than 26 percent of the AI/AN population -- nearly half a million people - lives with a significant physical and/or emotional disability. Many others experience the effects of less significant disabilities or disabilities that are "hidden," including many forms of mental illness and alcohol and substance abuse.

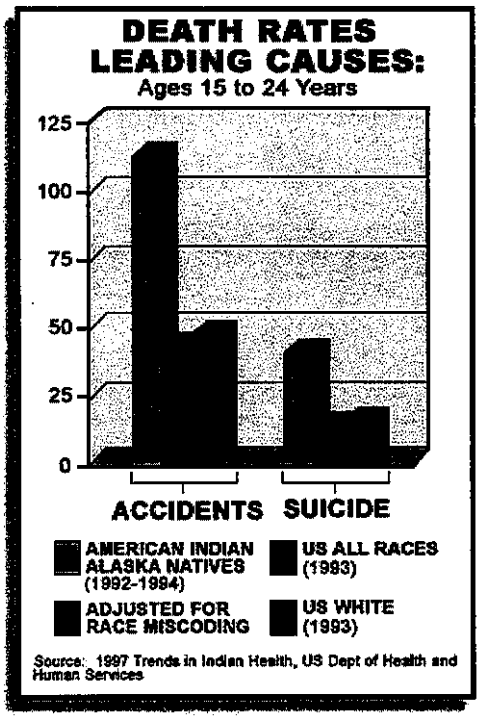
The overall suicide rate for the AI/AN population is approximately 72 percent higher than the national rate.

President Bush established the New Freedom Initiative on February 1, 2001 in response to the need to remove barriers to community living for people with disabilities. This Initiative "represents an important step in working to ensure that all Americans have the opportunity to learn and develop skills, engage in productive work, and choose where to live and participate in community life" (CMS, 2001). Widespread disability due to physical, emotional, social, and environmental influences has often limited the ability of AI/AN communities to care for disabled and elderly individuals.

Compared with the general population, in which the highest suicide rate is found for individuals aged 74 and older, the highest suicide rate is found for AI/ANs aged 15-34. The suicide rate for AI/AN males aged 15-34 is approximately 2.4 times the national rate or about 60 deaths per 100,000 population. AI/AN deaths due to accidents are approximately 3 times the rate for the general population. Many health professionals consider a substantial portion of deaths reported as accidents or injuries actually to be suicides. These facts point to the severity of mental health problems in AI/AN communities.

- The rates of violence for every age group are higher among AI/ANs than that of the general population. Statistics point to a considerable problem of violence perpetrated both by and against AI/AN youth. The rate of violence for AI/AN youth aged 12-17 is 65 percent greater than the national rate for youth. Gang membership is increasing within urban as well as reservation/rural communities. Seventeen percent of AI/ANs arrested for violent crimes are under the age of 18.

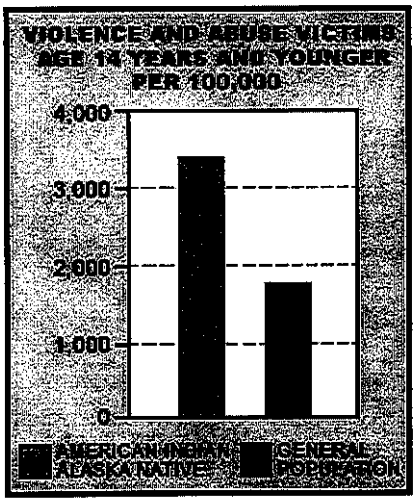
The rate of homicide in AI/AN communities is 41 percent higher (approximately 15.1 per 100,000) than the national rate. The greatest numbers of homicides occur in AI/AN males ages 15-44 and reaches nearly 40 deaths per 100,000 (2.7 times greater than the aggregate AI/AN population homicide death rate).

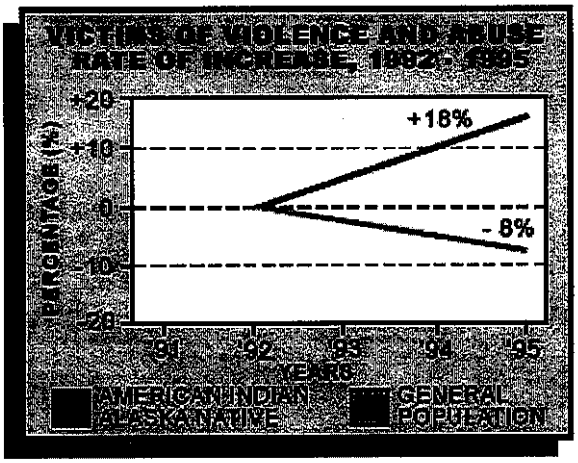


- Domestic violence and childhood sexual abuse are reported at alarming rates in AI/AN country. The homicide mortality rate for AI/AN female ages 25 to 34 years is about 1.5 times that for the general population of females in this age group.

- Over crowding in homes, lack of housing, and other socioeconomic issues are associated with high rates of abuse and neglect. High rates of lethal aggression are found among economically impoverished communities; the number of AI/AN families who are at or below the poverty level is 25.9 percent, a number significantly higher than for the general population. Over 75 percent of family violence victims report that the perpetrator had been drinking at the time of the offense as compared to approximately 49 percent for the general population.

- Problems of alcohol abuse, depression, and anxiety frequently underlie and complicate treatment for physical disorders and accidents. Alcoholism death rates are approximately 6.7 times the national rate (approximately 40 per 100,000 for the AI/AN population versus 5.9 for the general population). Liver disease, cancer, diabetes mellitus, heart disease, cerebrovascular disease, as well as other diseases occur in significantly higher proportions in AI/AN communities as compared to the general population. Chronic health problems, many of which are behaviorally related, impact psychological well-being. Individuals who experience chronic health problems are more likely to receive a diagnosis of depression and/or anxiety and to experience suicidal ideation. Given the high rates of physical and mental health problems, the implications for AI/AN individuals, families, and communities are evident. Please refer to the Alcoholism and Substance Abuse Program narrative for additional information about substance abuse concerns.





Services available to AI/AN communities for

serious mental health and social problems continue to be limited. The most common MH/SS program model is an acute, crises-oriented outpatient service staffed by one or more mental health professionals. On-call emergency mental health services are provided outside of usual clinic or hospital hours. Medical and clinical social work are usually provided by one or more social workers who assist with discharge planning and provide family intervention for child abuse, suicide, domestic violence, parenting skills, and marital counseling. Completing priorities over existing resources coupled with difficulties recruiting trained specialists substantially limits the availability of specialized mental health services for populations such as children and the elderly. Virtually no partial hospitalization, transitional living, or child residential mental health programs exist as a part of IHS or tribal operations; such services are obtained from local or state resources when available. Inpatient services are provided under contract with local general hospitals psychiatric units or private psychiatric hospitals. Emergency and long duration hospitalizations are provided by state mental hospitals. Such hospitals rarely consider cultural needs or offer culturally relevant services such as traditional healers in the healing process.

Many critical components of mental health, child abuse and social service programs, such as day programs, suicide prevention, and child abuse victim treatment are not available in AI/AN communities. The IHS continues to emphasize community wide intervention and prevention strategies in collaboration with tribes with the goal of improving long term health for child and family based problems. Prevention and early intervention, although legitimate needs, are often deferred so that crisis intervention may be provided.

Traditional healers are utilized in most AI/AN communities. At the option of individual tribes, traditional medicine is coordinated with other health and mental health services. Traditional healing practices are important health resources in AI/AN communities.

There is approximately 1 psychologist per 8,333 AI/ANs as compared to 1 per 2,213 for the general population.

Most service units and tribal programs are operated with little clinical staff backup because of the rural and isolated nature of their practice. Professional turnover and burnout also affect the availability of services. In addition to the limited numbers of mental health professional available to provide services for AI/AN communities, researchers also suggest burnout is related to secondary traumatic stress - the effect that hearing about and dealing with other's trauma has on the mental health professional.

ACCOMPLISHMENTS

In addition to providing prevention and intervention services, accomplishments of the Mental Health/Social Services Program include the following:

Children's Mental Health

Significant programmatic activities include:

- Grants to support tribal child abuse and family violence prevention programs and day treatment for mentally ill persons. Other support for child abuse prevention includes providing training to IHS and tribal providers in cooperation with the University of Oklahoma and the University of New Mexico. Joint efforts with the BIA on conducting background checks for tribal, IHS and BIA programs, and joint collaborations with the DOJ and tribes on developing community-based prevention/intervention initiatives for adolescent sexual abuse perpetrators.

- Continuation of a $2.4 million AI/AN children's mental health initiative with SAMHSA.

- Joint efforts with the Head Start Bureau that provide health and mental health consultation and training to 152 AI/AN Head Start and Early Head Start programs including family violence prevention and intervention.

- Reestablished the National Child Protection workgroup, an interagency collaboration with the BIA, DOJ, and IHS. This group developed a child protection manual to educate and inform individuals working in AI/AN communities about child protection laws, indicators, and reporting procedures.

- Developed a Child Sexual Abuse Examination Training and Telemedicine Project in collaboration with Office of Victim of Crimes (OVC). This project provides colposcopes and auxiliary equipment as well as training, consultation, and technical support for medical practitioners.

- Continued the Indian Children's Program for another year with an option to continue for two additional years. This provides a stronger focus on early identification and intervention with disabled children and their families.

- Training regarding the needs of high risk children and youth includes: the detection and intervention for emotionally disturbed youth and child abuse victims in BIA boarding schools; residential treatment centers (RTCs); tribal detention centers; and the Juvenile First Offender Diversion Program training in AI/AN communities with the Office of Juvenile Justice and Delinquency Prevention (OJJDP).

Major Partnerships

Major partnerships currently exist with Bureau of Indian Affairs (BIA), Substance Abuse and Mental Health Service Administration (SAMHSA), Center for Disease Control (CDC), Department of Justice (DOJ) and Administration for Children and Families (ACF). These partnerships often provide for increased services to AI/AN communities

- Developed a federal and non-federal interagency AI/AN Youth Violence workgroup for the purpose of information dissemination and education.

- Participation in multi-agency Area Child Protective Teams. These teams are designed to ensure communication, cooperation, and follow-through with neglect/abuse cases.

- Collaboration with the BIA, DOJ, CDC, as well as other national, state, and local agencies in providing training and consultation to I/T/U providers about domestic violence, child abuse, and elder abuse. Also, an IHS system wide identification and intervention for victims of domestic violence will continue in the I/T/U health facilities.

- Participated in a number of interagency activities, such as meetings and workgroups, with SAMHSA, the Office of Justice Juvenile Detention Program, and the National Center for Child Abuse and Neglect, and the BIA that have positively impacted services for AI/AN communities.

- Renewed several interagency agreements that have resulted in increased resources for AI/AN communities. These include agreements with: (a) the OVC to provide funds to IHS for Child Protection Team Training; (b) SAMHSA to support an AI/AN Technical Assistance Center for the nine AI/AN grantees selected for the Circles of Care Children's Mental Health Initiative and to the three AI/AN Children's Mental Health Service grantees; (d) the Office of Child Abuse and Neglect to continue support of Project Making Medicine at the University of Oklahoma which provides training in child abuse treatment to IHS and Tribal mental health, social service, and substance abuse providers and training and technical assistance to their communities. This project also provides training and technical assistance to the American Indian Program Branch/Headstart grantees.

- Continued implementation of suicide prevention strategies in collaboration with CDC including development of a tribally based national suicide prevention network/center.

- Provided mental health training and program consultation to eleven adolescent Regional Treatment Centers. See Alcoholism and Substance Abuse narrative for additional information.

- Funded eight 3-year Mental Health and Community Safety Initiative grants. This represents the IHS portion of a collaborative effort with DOJ, BIA, DOE, and SAMHSA providing over $5 million total in grants to AI/AN communities each year.

Training and Development

Training and development remain priorities not only to help existing staff keep current of advancements in treatment and prevention, but as a means to recruit behavioral health care providers into AI/AN communities.

- Continued the Social Work Fellowship Program with the University of New Mexico that provides child-specific training for AI/AN professionals.

- Continued the Southwest Consortium Pre-doctoral Psychology Internship program that provides training for one intern. This intern provides direct psychological services in the IHS Albuquerque Service Area; AI/AN preference is given to this position.

- Continued funding for the Annual Conference for Psychologists and Psychology students, a forum for students to present their research, develop mentorship relationships, and for I/T/Us to recruit mental health and social service providers.
- Developed and provided a national Behavioral Health Conference for I/T/U behavioral health providers, administrators, and other interested parties. Federal partners were invited to participate as well as grantees.

Data Collection

- Expansion of the MH/SS system in the I/T/U facilities for mental health data collection including suicide, child abuse, and domestic violence in addition to other clinical information. Data for baseline morbidity are essential to fully support the I/T/U planning and management of health programs.

PERFORMANCE PLAN

The following performance indicators are included in the IHS FY 2003 Annual Performance Plan. These indicators are sentinel indicators representative of some of the more significant health problems affecting AI/AN. It was proposed that, at the FY 2003 budget authority level, IHS could achieve the following:

Indicator 15: During FY 2003 the IHS will address domestic violence, abuse, and neglect by assuring that:

a. at least 85 percent of I/T/U medical facilities (providing ER and urgent care) will have written policies and procedures for routinely identifying and following:
    a. intimate partner abuse (IPV)
    b. child abuse and/ or neglect
    c. elder abuse and/ or neglect
b. at least 60 percent of I/T/U medical facilities (providing direct patient care) will provide training to the direct clinical staff on the application of these policies and procedures
c. a standard data code set is developed for the screening of intimate partner abuse in conjunction with the Family Violence Prevention Fund and AHRQ

Indicator 17: During FY 2003, improve the Behavioral Health Data System by:

a. Assuring at least 50 percent of the I/T/U programs will report minimum agreed-to behavioral health-related data into the national data warehouse.
b. Increasing the number of I/T/U programs utilizing the RPMS behavioral health data reporting systems by 5 percent over the FY 2002 rate.

Indicator 27: During FY 2003, increase by 5 percent over the FY 2002 level, the proportion of I/T/Us that have implemented systematic suicide surveillance and referral systems which include:

a. monitoring the incidence and prevalence rates of suicidal acts (attempts, and completions)

b. assuring appropriate population-based prevention and interventions are available and services are made accessible to individuals identified at risk

Funding for the Mental Health programs during the last five years has been as follows:

Year	Funding	FTE
1998	$39,379,000	308
1999	$41,305,000	290
2000	$43,245,000	283
2001	$46,579,000	279
2002	$47,142,000	285

RATIONALE FOR BUDGET REQUEST

Total Request -- The request of $52,499,000 (including accrued costs of $1,873,000) and 307 FTE is an increase of $3,657,000 and 22 FTE over the FY 2002 enacted level of $47,142,000 plus accrued cost of $1,700,000 and 285 FTE. The increases are as follows:

Pay Cost Increases: +$1,508,000

The request of $1,508,000 for Federal/Tribal pay costs would fund in-part the increases associated with on-going operations.

The IHS continues to strive to increase access for the IHS patient population. Maintaining the current I/T/U health system is necessary in eliminating disparities in health status between AI/AN and the rest of the U.S. population.

Phasing-In of Staff for New Facilities: +$2,149,000 and 22 FTE

The request of $2,149,000 and 22 FTE provides for the phasing-in of staff and related costs for new facilities. Staffing new facilities also contributes to the need for recruitment and retention of mental health and medical staff as well as promotes self-determination activities.

The following table displays the requested increase.

Facilities	**Dollars**	**FTE**	**Tribal**
Ft. Defiance, AZ Hospital	$1,961,000	21	0
Parker, AZ Health Center	94,000	1	0
Winnebago, NE Hospital	94,000	0	1
Total	$2,149,000	22	1

Accrued Retirement and Health Benefits Costs

The increase of $173,000 is associated with the proposed Managerial Flexibility Act of 2001; **the full accrued cost in FY 2003 for Mental Health is $1,873,000.** This legislation requires agencies, beginning in FY 2003, to pay the full Government share of the accruing cost of retirement for current CSRS, CIA and Foreign Service employees, and the Coast Guard, Public Health Service and NOAA Commissioned Corps. The legislation also requires agencies to the pay full accruing cost of post-retirement health benefits for current

present the full costs of Federal employees in the accounts and programs where they are employed. This legislation is part of an initiative to link budget and management decisions to performance by showing the full cost of each year's program operations together with the output produced that year. These accrual costs are shown comparably in FY 2001 and FY 2002.

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ALCOHOL & SUBSTANCE ABUSE

Indian Health Service

Clinical Services	2001 Actual	2002 Appropriation	2003 Estimate	Increase Or Decrease
Alcohol & Substance Abuse				
A. Current Law BA	$130,254,000	$135,005,000	$137,744,000	+$2,739,000
B. Accrued costs 1/	967,000	1,031,000	1,056,000	+25,000
C. Proposed Law BA	$131,221,000	$136,036,000	$138,800,000	+$2,764,000
D. FTE	173	173	173	0
E. Services Provided:				
Outpatient Visit	750,000	750,000	718,000	-32
Inpatient Day	365,000	365,000	350,000	-15
F. Regional Trt Ctr:				
Admission	4,700	4,700	4,498	-202
Aftercare Referrals	11,100	11,100	10,622	-478
Emergency Placements	500	500	478	-22

1/ Please see Exhibit S for the crosswalk from current law to proposed law to reflect the Administration's proposal for full accrued retirement and health benefits.

PURPOSE AND METHOD OF OPERATION

Program Mission/Responsibilities

The Alcoholism and Substance Abuse Program (ASAP) activities are part of a Behavioral Health Team that works collaboratively to eliminate the disease of alcoholism and other drug dependencies and the associated pain it brings to individuals of all ages, families, villages, communities, and tribes. The primary goal is to reduce the prevalence and incidence of alcoholism and other drug dependencies. The ASAP provides support and resources for AI/AN communities toward achieving excellence in alcohol and other drug dependency treatments, rehabilitation, and prevention services for individuals and their families. In addition to the development of curative, preventative and rehabilitative services, the ASAP activities include:

- Development and coordination of an integrated information management system that measures substance abuse and alcohol problems with co-occurring mental health and case management issues among AI/AN;

- Provision for evaluation and research activities to facilitate the rebuilding, restructuring, and creation of AI/AN community based programs that provide for the development of effective prevention and treatment services;

- Promotion of national leadership that focuses on early prevention and intervention services for high risk youth in treatment, community education, and prevention services.
- Diagnostic, assessment and referral services for children and adults with FAS and FAE and to provide family and community education services for appropriate case-management, treatment and coordination of services.

The Indian Health Service Behavioral Health Program continues to provide Alcohol/Substance abuse program services primarily through self-determination contracts with tribal entities/consortia including Indian-managed urban health boards. Since the passage of the Indian health Care Improvement Act, P.L. 94-437, the IHS has funded approximately 300 AI/AN programs that provide holistic and culturally based alcohol/substance abuse treatment and prevention services to rural and urban communities.

Best Practices/Industry Benchmarks

Approximately 5 percent of the estimated 1,800 employees in IHS-funded ASAP are Federal staff with Tribal staff comprising 95 percent. The credentialing, training, and hiring of 1,200 counselors have been a major initiative to address counselor competency. The reported certified counselor and professional licensure rates continue at the 85 percent level of the program staff.

There are four Youth Regional Treatment Centers (YRTC) accredited by the Joint Commission of Accreditation of Healthcare Organizations (JCAHO) and four YRTC's that are accredited by Commission on Accreditation of Rehabilitation Facilities (CARF). Two of the three remaining facilities are state licensed/certified, and the remaining facility is currently preparing for CARF accreditation.

Many of the tribal alcohol programs are state licensed and/or certified. The majority of the tribal alcohol programs follow the Indian Health Manual, Part III, Chapter 18, ASAP Standards that are modeled after JCAHO and CARF Standards.

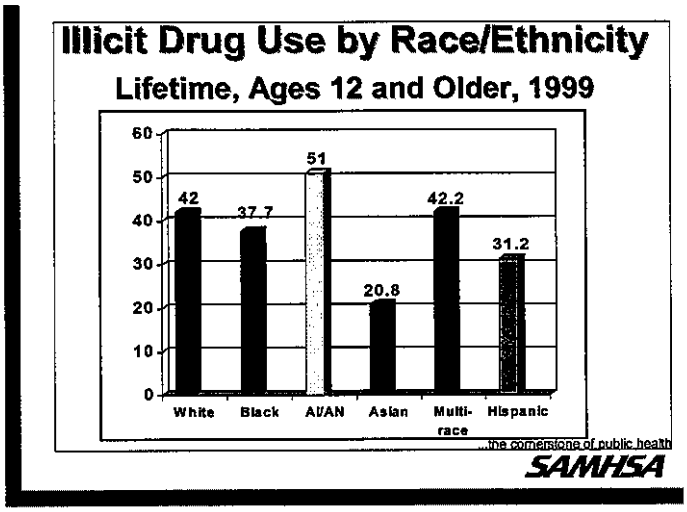
Additional resources for residential and non-residential facilities to correct identified areas for improvement requires prioritization and commitment to improve alcoholism and substance abuse programs. For example, an evaluation of the effectiveness of IHS sponsored aftercare/continuing care service is underway though other program efforts remain to be evaluated when resources allow.

Findings Influencing FY 2003 Request

The latest data indicates that alcoholism mortality rates in some tribal communities have increased significantly since 1992. When the 1992-1994 alcoholism death rate is adjusted for miscoding of Indian race on death certificates, it increases from 39.4 per 100,000 to 45.5 per 100,000, nearly 7 times the alcoholism death rate of the overall U.S. population. The AI/AN drug-related death rate is 18 percent higher than the rate for the overall U.S. population. In an evaluation study of the Youth Regional Treatment Centers (YRTC), problem severity in AI/AN youth appears to be more treatment intensive in comparison to

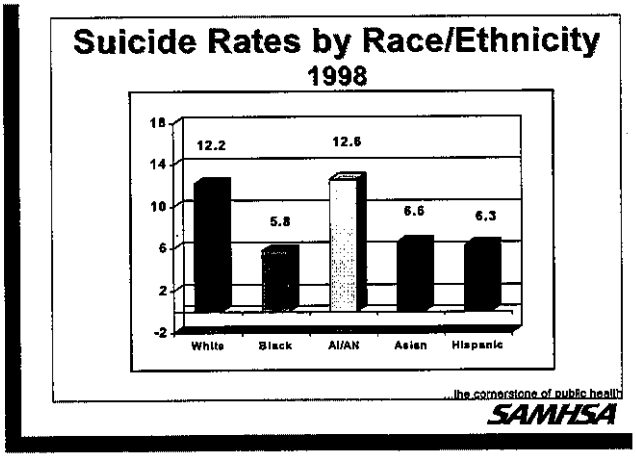
the general U.S. population as indicated by program completion rates of 53 percent versus 61 percent of the general population. Comprehensive care requirements favor dually trained staff in mental health and alcohol/substance abuses disorders to effectively and safely meet the needs of young people with diagnosed dual disorders.

The 1999 Substance Abuse and Mental Health Services Administration (SAMHSA) data show that compared to all races and ethnic groups, AI/ANs Ages 12-17 have the highest alcohol use rates (Past Month).



Data for 1999 show that AI/ANs have the highest lifetime illicit drug use for ages 12 an older compared to all races and ethnic groups.

The high rates of alcohol and illicit drug use are significant as independent issues but alarming when joined with high suicide rates, as reflected in SAMSHA data for 1998 by race and ethnicity.



ACCOMPLISHMENTS

Interagency Activities

In FY 2001, the IHS Alcoholism and Substance Abuse Program (ASAP) collaborated with Substance Abuse and Mental Health Services Administration (SAMHSA), Centers for Disease Control and Prevention (CDC), Center for Medicare and Medicaid Services (CMS), Bureau of Indian Affairs (BIA), Housing and Urban Development, Department of Transportation, and the Department of Justice (DOJ).

Local, community based training workshops and events called "Gathering of Native Americans," are being widely adapted throughout Indian Country. These workshops and events have been designed, tested, and evaluated in American Indian communities with the help of Indian education, social services and health professionals supported by both the IHS and the SAMHSA Center for Substance Abuse Prevention (CSAP). These workshops have revitalized community planning interest and capabilities for addressing alcoholism and substance abuse.

- Coordination with the Centers for Disease Control and Prevention to fund an injury management control officer and a tobacco education and training officer.

- Two IHS ASAP staff members work two days per week within the Center for Substance Abuse Treatment (CSAT) and the Center for Substance Abuse Prevention (CSAP) respectively. This cooperative effort continues to increase the national consultation and collaboration for AI/AN behavioral health issues.

- Numerous clinics and hospitals in the Aberdeen Area are using the CDC developed Prenatal Health Assessment screening instrument for pregnant substance abusing women. In 2001, the IHS Substance Abuse Program supported an analysis of data from this project.

- IHS continues to fund Fetal Alcohol and Drug Unit mini-internships at the University of Washington for I/T/U providers.

- IHS continues to work with the Office of National Drug Control Policy, the Department of Transportation, Bureau of Indian Affairs, Department of Justice, and the Housing and Urban Development to co-sponsor and develop an Annual National Tribal Leaders Best Practices Substance Abuse Summit. The first summit occurred in 2000.

Professional Development

- The IHS continues to support primary care provider training workshops to enhance professional skills in addiction, prevention, intervention, and treatment. The training content has been updated. Between 40 to 60 primary care providers receive this training each year. Activities include the development of a lending library (video and slide materials) to improve provider in-service capability and community presentations.

- Counselor certification and professional licensure rates continue at approximately 85 percent of the program staff. New funding will be used, in part, to improve the rate of licensure and/or certification for IHS-funded ASAPs.

- Clinical supervision/training continues as in previous fiscal years to enhance counseling efforts.

Information Management

- Activities are underway to merge the Chemical Dependency Management Information System (CDMIS) with the Social Services and Mental Health reporting system. The data merger will provide more information on the full range of behavioral health issues facing the AI/AN people. Funds available in 2003 are being used to initiate data merger activities including assessment, equipment, and training. The accomplishments in this area are supported by the funds received from H.R. 5666, "Miscellaneous Appropriations."

- Previous CDMIS data management activities integrated commercial and RPMS data facilitating a behavioral health treatment model. The integrated data system is being tested in the Billings Area. The ASAP is supporting two software enhancement projects that further integrate and coordinate assessment, treatment planning, and case management utilizing the American Society of Addiction Medicine (ASAM) Patient Placement criteria and the CSAT Alcohol Severity Index (ASI). Systems are being tested at 10 YRTCs and in the Billings Area.

Fetal Alcohol Syndrome

- Leadership is being provided for the prevention of secondary disabilities in FAS individuals. A training manual was prepared in conjunction with the Jamestown S'Klallam Tribe for providers, parents, and caregivers of FAS children and adolescents. The IHS is responding to a high volume of requests for the manual. Additional activities during 2002 included the development of a manual for caregivers of FAS/FAE children and related materials.

- Funds were provided early in FY 2001 from a congressional earmark for SAMHSA to administer through the Center for Substance Abuse Prevention for an FAS/FAE project. The funds were awarded to a four-state consortium that includes Montana, North Dakota, South Dakota and Minnesota. Each state within the consortium is working on a state-specific FAS/FAE plan. The consortium states are working together to identify high-risk populations, test interventions, and collect data. All citizens in the four states are a part of the target population, however, specific high-risk groups will be identified. It is expected that AI/ANs will figure into the high-risk populations for FAS/FAE.

- The IHS continues to participate in the Federal Interagency Coordinating Committee to improve services and access to care for FAS/FAE children and their families.

Treatment for Women

- The IHS is initiating new activities in the ongoing effort to evaluate alcohol and substance abuse treatment for AI/AN women. In a final IHS ASAP report, dated, January 2001, data indicates that alcohol and substance abuse accounts for 25 percent of the deaths for AI/AN women. The factors critical to successful treatment include childcare. The IHS will continue to work with the BIA to address childcare and women's treatment in concert with the BIA.

Future Directions

The IHS actively cooperates with DHHS, and other agencies in developing policy research agendas, and data monitoring. The IHS seeks to reduce alcohol and drug abuse by using strategies that include:

- Research and evaluation of collaborative efforts and after-care evaluation.

- Continue development of a comprehensive continuum of care encompassing prevention, education, treatment and rehabilitation. Workshops on American Society of Addiction Medicine Patient Placement Criteria will be continued.

- Initiative to support treatment and prevention for women and men.

- Support inhalant abuse prevention and treatment initiative as a gateway drug in children, including Head start, and young adolescents.

- Injury control projects, e.g., Healthy People 2010 objectives.

- Continue efforts in enhancement of counselor skills.

- Tobacco cessation programs.

- Continue implementation of a planned integration of RPMS and standardized commercial behavioral health software to enhance the treatment plans, evaluation of services, and improve third party reimbursement.

- Expand primary prevention efforts via collaboration with the Center for Substance Abuse Prevention and other agencies.

- Coordinate with the BIA to work with the Tribes to review and update community plans and action items that address alcohol and substance abuse issues.

- Continue to work with States and other Federal agencies to assist Tribes in accessing available competitive grants that are effective in the AI/AN communities.

- Expand on previous work to determine resources needed to provide behavioral health services (an integrated model of mental health and substance abuse/alcohol programs).

- Expand on traditional healing efforts that are showing increasing benefit in many AI/AN communities.

- Continue enhancement of YRTCs development and effectiveness.

- Continue to enhance and improve aftercare services available to youth.

- Continue ONDCP/IHS meetings to address the national adolescent inhalant abuse issue.

- Participate with CSAT and the Administration for Children and Families to conduct four regional meetings for child welfare and substance abuse issues. Continue IHS/CSAP initiatives with Tribal Colleges and Universities and the three-year, tri-state FAS/FAE project in the Billings, Aberdeen, and Bemidji Areas. Expand the IHS Elder Care Initiative by broadening the assessment of AI/AN elders to include alcohol

PERFORMANCE PLAN

The following performance indicators are included in the IHS FY 2003 Annual Performance Plan. These indicators are sentinel indicators representing the more significant health problems affecting AI/AN. At the FY 2003 funding level, IHS would be able to achieve the following:

Indicator 9: During FY 2003, Regional Treatment Centers will collectively achieve at least a 5 percent increase over the FY 2002 baseline for each of the following criteria:

a. percent of youths who successfully completed alcohol/ substance abuse treatment at IHS funded Residential Youth Treatment Centers
b. percent of youth (that completed treatment) who developed an aftercare plan with their appropriate aftercare agency
c. percent of youth who have this after care plan communicated to the responsible follow-up agency; documentation of this communication must be in the youth RTC record
d. percent of RTC programs that have a family week opportunity for youth that participate in the Regional Treatment Centers

Indicator 10: During FY 2003, maintain the proportion of I/T/U prenatal clinics utilizing a recognized screening and case management protocol(s) for pregnant substance abusing women at the FY 2002 level.

Funding for the Alcohol program during the last five years has been as follows:

Year	Funding	FTE
1998	$91,782,000	184
1999	$94,680,000	186
2000	$96,824,000	175
2001	$131,221,000	173
2002	$135,005,000	173

In H.R. 5666, "Miscellaneous Appropriations", as Actual by the Consolidated FY 2001 Appropriations Bill (HR 4577), Congress made a $15 million direct lump sum appropriation to the Alaska Federation of Natives (AFN) for its "Alaska Native Sobriety and Alcohol Control Program" that allows the AFN to make grants to each of the regional Alaska Native corporations to ban the sale, importation, and possession of alcohol pursuant to local option state law. An additional $15 million is provided to the IHS for the non-Alaska Tribes for drug and alcohol prevention and treatment services. A portion of the funds will be used to support the national data consolidation project. The remainder of the funds was distributed to each of the Areas to spend on alcohol and substance abuse priorities, including.

RATIONALE FOR BUDGET REQUEST

Total Request -- The request of $138,800,000 (including accrued costs of $1,056,000) and 173 FTE is increase of $2,764,000 over the FY 2002 enacted level of $135,005,000 plus accrued cost of $1,031,000 and 173 FTE. The increase includes the following:

Pay Cost Increases: +$2,764,000

The request of $2,764,000 for Federal/Tribal pay costs would fund the increases associated with on-going operations.

The IHS continues to strive to increase access for the IHS patient population. Maintaining the current I/T/U health system is necessary in eliminating disparities in health status between AI/AN and the rest of the U.S. population.

Accrued Retirement and Health Benefits Costs

The increase of $25,000 is associated with the proposed Managerial Flexibility Act of 2001; **the full accrued cost in FY 2003 for Alcohol and Substance Abuse is $1,056,000.** This legislation requires agencies, beginning in FY 2003, to pay the full Government share of the accruing cost of retirement for current CSRS, CIA and Foreign Service employees, and the Coast Guard, Public Health Service and NOAA Commissioned Corps. The legislation also requires agencies to the pay full accruing cost of post-retirement health benefits for current civilian employees. The intention of the legislation is to budget and present the full costs of Federal employees in the accounts and programs where they are employed. This legislation is part of an initiative to link budget and management decisions to performance by showing the full cost of each year's program operations together with the output produced that year. These accrual costs are shown comparably in FY 2001 and FY 2002.

ALCOHOLISM AND SUBSTANCE ABUSE PREVENTION/TREATMENT PROGRAM AUTHORIZED UNDER P.L. 103-572
(DOLLARS IN THOUSANDS)

Amount of Funds	FY 1993 Appropriation	FY 1994 Appropriation	FY 1995 Appropriation	FY 1996 Appropriation	FY 1997 Appropriation	FY 1998 Appropriation	FY 1999 Appropriation	FY 2000 Appropriation	FY 2001 Appropriation**	FY 2002 Appropriation	FY 2003 President's Budget
Adult Treatment	$47,232	$49,566	$51,693	$51,693	$51,766	$51,936	$53,576	$54,789	$73,769	$76,459	$78,011
Regional Treatment Centers	12,407	14,040	14,013	14,013	14,033	14,079	14,523	14,852	17,684	18,329	18,701
Community Education & Training	2,594	2,726	2,880	2,880	2,884	2,894	2,985	3,053	6,852	7,102	7,247
Community Rehabilitation/ Aftercare	11,880	13,593	15,088	15,088	15,109	15,159	15,638	15,992	22,259	23,071	23,539
Gila River		135	135	135	135	136	140	143	170	177	180
Contract Health Service	5,920	6,221	6,209	6,209	6,218	6,238	6,435	6,581	7,836	8,122	8,286
Navajo Rehab. Program	237	249	239	239	239	240	248	253	302	313	319
Urban Clinical Services	450	473	509	509	510	511	528	539	642	666	679
Wellness Beyond Abstinence	585	614	586	586	587	589	607	621	740	767	782
Total	$81,305	$87,617	$91,352	$91,352	$91,482	$91,782	$94,680	$96,824	$130,254	$135,005	$137,744

URBAN HEALTH PROGRAM 1/

Amount of Funds	FY 1993 Appropriation	FY 1994 Appropriation	FY 1995 Appropriation	FY 1996 Appropriation	FY 1997 Appropriation	FY 1998 Appropriation	FY 1999 Appropriation	FY 2000 Appropriation	FY 2001 Appropriation	FY 2002 Appropriation	FY 2003 Presidents Budget
Expand Urban Programs	2,828	2,972	3,044	3,045	3,045	3,048	3,180	3,239	3,367	3,491	3,557

INDIAN HEALTH FACILITIES 2/

Amount of Funds	FY 1993 Appropriation	FY 1994 Appropriation	FY 1995 Appropriation	FY 1996 Appropriation	FY 1997 Appropriation	FY 1998 Appropriation	FY 1999 Appropriation	FY 2000 Appropriation	FY 2001 Appropriation	FY 2002 Appropriation	FY 2003 Presidents Budget
Construction	7,929	2,780	0	0	0	0	0	0	0	0	0
Alcohol/Substance Abuse	**$81,305**	**$87,617**	**$91,352**	**$91,352**	**$91,482**	**$91,782**	**$94,680**	**$96,824**	**$130,254**	**$135,005**	**$137,744**
Urban Health Program	**2,828**	**2,972**	**3,044**	**3,045**	**3,045**	**3,048**	**3,180**	**3,239**	**3,367**	**3,491**	**3,557**
Facilities Construction	**7,929**	**2,780**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
GRAND TOTAL	**$92,062**	**$93,369**	**$94,396**	**$94,397**	**$94,527**	**$94,830**	**$97,860**	**$100,063**	**$133,621**	**$138,497**	**$141,301**

**These amounts are subject to change as the distribution of the additional $30 million appropriated under Labor, HHS is pending consultation and approval by the Tribes.
1/ The Urban Program was funded under P.L. 100-690, and now is funded under P.L. 103-572.
2/ These funds included in the Outpatient Sub-sub-activity.

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CONTRACT HEALTH SERVICES

Indian Health Service

Clinical Services	2001 Actual	2002 Appropriation	2003 Estimate	Increase or Decrease
Contract Health Services				
A. Current Law BA	$445,773,000	$460,776,000	$468,130,000	+$7,354,000
B. Accrued costs	0	0	0	0
C. Proposed Law BA	$445,773,000	$460,776,000	$468,130,000	+$7,354,000
D. Gen. Med & Surg. Hospitalization: ADPL	252	248	244	-4
E. Ambulatory Care: Outpatient Visits	541,600	507,305	492,700	-14,605
F. Patient & Escort Travel: One Way Trips	39,600	37,007	35,947	-1,090
G. Dental Services	66,900	61,678	60,926	-752

PURPOSE AND METHOD OF OPERATION

Program Mission and Responsibilities

The IHS Contract Health Services (CHS) program supplements the health care resources available to eligible American Indian and Alaska Native (AI/AN) people with the purchase of medical care and services that are not available within the IHS direct care system. The IHS purchases both basic and specialty health care services from local and community health care providers, including hospital care, physician services, outpatient care, laboratory, dental, radiology, pharmacy, and transportation services such as ground and air ambulance. The CHS program also supports the provision of care in IHS and tribally operated facilities, such as specialty clinics, e.g., orthopedics and neurology, and referrals to specialists for diagnostic services.

The CHS program is administered through 12 IHS Area Offices that consist of 66 IHS-operated Service Units and 84 tribally operated health programs. Although the IHS facilities include two major medical centers, and one tribally medical center most of the IHS and tribally operated facilities are small rural community hospitals and health centers with basic primary care services. In addition, not all tribes have access to IHS or tribally operated facilities or have limited access. Therefore, those Areas with few or no direct care facilities have a higher reliance on the CHS program to provide the needed health care.

The CHS budget includes a Catastrophic Health Emergency Fund (CHEF) of up to $18,000,000 that is intended to protect local CHS operating budgets from overwhelming expenditures for certain high cost cases. To access the CHEF program, a threshold has to be met first which is based on the annual change in the consumer price index as mandated by congressional

legislation, in FY 2001 the threshold was $20,800 and increased to $21,700 in FY 2002. Once the threshold is met, the $15 million CHEF budget for FY 2001 provided funds for more than 800 high cost cases in amounts ranging from as low as $1,000 to $600,000 per case. The FY 2003 Budget increases CHEF up to $18,000,000.

Best Practices/Industry Benchmarks

Because of high patient demand, the IHS relies on strict adherence to specific CHS guidelines to ensure that the most effective use of CHS dollars is attained. As much as possible, the IHS pursues negotiated rate agreements with private health care providers to obtain health care at reduced rates, including managed care arrangements. In addition to the CHS requirement for eligibility, the IHS utilizes a medical priority system and is considered to be the payer of last resort. This means that all alternate resources that a patient is eligible for must be first exhausted, before the IHS can pay. Tribal contractors generally provide services under the same CHS regulations as the IHS.

In addition, the IHS fiscal intermediary (FI) contract with Blue Cross/Blue Shield of New Mexico provides a mechanism of payment to services in the private sector. The FI ensures that payments are made accurately and timely according to contractual requirements where applicable, and maintains a centralized medical and dental claims reimbursement system. The FI process functions within the IHS payment policy and meets the standards of the medical industry. In addition to providing payments to vendors, the FI provides program support services that collects, compiles, organizes workload, and financial data, and generates statistical reports to the IHS that support the administration of CHS programs.

Findings Influencing FY 2003 Request

Increased costs for professional care services:

- According to the Bureau of Labor Statistics, the Consumer Price Index for Medical Care increased 4.1 percent between 1999 and 2000, whereas for professional care services the IHS FI reported an increased cost of 9.86 percent for 2001.

ACCOMPLISHMENT

IHS patients have been able to receive more health care services than the amount of CHS expenditures indicate. This is accomplished through a variety of mechanisms such as alternate resource requirements, and provider discounts/contracts.

Alternate resource (AR) means other third party payers must pay before the IHS will pay. To accomplish this patients are required to inform the Service what type of AR they have and must apply if they are potentially eligible for an AR. Examples of an AR include private insurance companies, Medicare, and Medicaid.

Provider discounts/contracts are agreements to reimburse health care providers at an amount below billed charges. Types of provider reimbursement contracts at a discount include, payment using Medicare methodology, a percent of Medicare methodology, per diem rates, and percent of billed charges (if less than Medicare).

Because of the procedures described above, the CHS program has been able to purchase health care services that total more than twice the amount of the CHS expenditures. The actual amount of billed charges purchased through these arrangements cannot be completely documented because the IHS only has records for payments actually made. For example, payments by Medicaid are considered payment in full in accordance with Federal regulation. Therefore, when a patient is eligible for Medicaid and Medicaid pays the bill there are no charges to be paid by the Service or the patient.

The IHS will continue to use the FI to process and pay CHS claims and recommend its use to tribes because it increases the amount of services that can be purchased by monitoring alternate resources, etc.

PERFORMANCE PLAN

The FY 2003 funding request for Contract Health Services will contribute to the accomplishment of the performance indicators below, which are included in the FY 2003 Annual Performance Plan. These indicators are sentinel indicators, representing some of the more significant health programs affecting AI/AN.

Indicator 6: During FY 2003, maintain the proportion of eligible women who have had a Pap screen within the previous three years at the FY 2002 levels.

Indicator 7: During FY 2003, maintain mammography screening at the FY 2002 rate.

Indicator 8: During FY 2003, maintain the proportion of AI/AN children served by IHS receiving a minimum of four well-child visits by 27 months of age at the FY 2002 level.

Indicator 23: In FY 2003, maintain FY 2002 levels in the proportion of AI/AN children who have completed all recommended immunizations for ages 3-27 months, as recommended by Advisory Committee on Immunization Practices.

Indicator 24: During FY 2003, maintain FY 2002 influenza vaccination rates among non-institutionalized adults aged 65 years and older.

Funding for the Contract Health Service program during the last five years has been as follows:

Year	Funding	FTE
1998	$373,375,000	2
1999	$385,801,000	0
2000	$406,756,000	0
2001	$445,773,000	0
2002	$460,776,000	0

RATIONALE FOR BUDGET REQUEST

Total Request -- The request of $468,130,000 is an increase of $7,354,000 over the FY 2002 enacted level of $460,776,000. The increase is as follows:

Pay Cost Increases: +$3,000

The request of $3,000 for Federal pay costs would fund the increases associated with on-going operations.

The IHS continues to strive to increase access for the IHS patient population. Maintaining the current I/T/U health system is necessary in eliminating disparities in health status between AI/AN and the rest of the U.S. population.

Contract Health Services: +$7,351,000

The IHS continues to strive to increase access for the IHS patient population. Maintaining the current I/T/U health system is necessary in eliminating disparities in health status between AI/AN and the rest of the U.S. population.

INDIAN HEALTH SERVICE	2001 Actual	2002 Appropriation	2003 Estimate	Increase Or Decrease
A. Current Law BA	$3,810,000	$3,886,000	$3,938,000	+$52,000
B. Accrued Costs	0	0	0	0
C. Proposed Law BA	$3,810,000	$3,886,000	$3,938,000	+$52,000
(FTE)	(15)	(15)	(15)	(15)

	2001 Enacted	2002 Appropriated	FY 2003 Request	Increase or Decrease
Risk Assessment & Prevention Surveys				
1. HIV Surveys	$994,000	$1,012,000	$1,027,000	+$15,000
Information & Education/Preventive Svcs				
1. High Risk and Infected Persons				
a. Hlth. Educ./Risk Reduction	535,000	535,000	535,000	0
b. Counseling, Testing & Partner Notification	224,000	228,000	231,000	3,000
Subtotal	759,000	763,000	766,000	+3,000
2. Special Minority Initiatives	791,000	820,000	841,000	+16,000
3. School and College Aged Youth				
a. Program Devel. & Training	224,000	228,000	231,000	+3,000
4. General Public & Special Prog.				
a. Regional, State, & Local	820,000	835,000	847,000	+12,000
5. Health Care Workers & Providers				
a. Other Types of Training	224,000	228,000	231,000	+3,000
Subtotal, Info. & Educ./Prev. Svcs	2,816,000	2,874,000	2,911,000	+37,000
Total	$3,810,000	$3,886,000	$3,938,000	+$52,000

PURPOSE AND METHOD OF OPERATION

The Public Health Service (PHS) mission for addressing Acquired Immune Deficiency Syndrome (AIDS) and the Human Immunodeficiency Virus (HIV) epidemic is to prevent further spread of the HIV virus; to provide effective therapies for those already infected; to enhance the capacity of the Nation's public and private organizations at the national, state, and local levels to deliver effective prevention, treatment, and related health care programs to all citizens. To achieve the PHS HIV/AIDS mission, the IHS has implemented programs that include components of risk assessment, education, and prevention to health care workers and American Indian and Alaska Native communities, and treatment of those that have progressed to AIDS and HIV infected persons. Surveys are conducted (questionnaire) that answer questions about what people know about HIV and AIDS.

ACCOMPLISHMENTS

Surveillance

New HIV infection cases average 120 per year for males. The female HIV infection rate continues to climb and will not stabilize for several more years. Last year there were 33 new female HIV infections. This year there are 50 new HIV infections. The surveys of prenatal, sexually transmitted diseases (STD), and alcohol and drug abuse treatment programs have proved the presence of the virus in virtually all remote Indian communities.

> As of June 2000, the IHS has reported 2,234 AIDS cases in AI/ANs.

Each IHS Area Office has one full or part-time HIV/AIDS Coordinator that networks with their respective State epidemiologist regarding HIV/AIDS in AI/ANs to enhance surveillance, prevention and treatment efforts. All programs must meet State-reporting requirements. Information is shared with the States and the Centers for Disease Control and Prevention. IHS has one National AIDS Coordinator in Headquarters.

High Risk or Infected Persons

More than 2,000 health care workers in IHS and tribal programs are trained as HIV counselors. This includes substance abuse counselors and mental health program staff.

Risk assessment behavior screening is continuing among women seen in prenatal and other clinics. Similar screening is being done on STD and tuberculosis patients.

With the increased public awareness of the HIV virus, more individuals are seeking counseling and requesting HIV testing. IHS is providing approximately 5,000 voluntary confidential tests annually.

Prevention Services

The IHS AIDS Program is focusing prevention activities in special groups, such as women, tribal leaders, school age youth, community leaders at specific community events such as feasts, pow-wows, schools, health fairs, and rodeos.

Special Emphasis - Urban Prevention Program

The Urban Indian Health programs received a special appropriation of $646,000 in FY 1993 for AIDS education and prevention services. Urban Indian programs now provide testing for high-risk individuals. Some continue to participate in the IHS surveillance.

The programs have developed culturally appropriate HIV Prevention materials, and have identified available resources for care. Initially, the 34 urban Indian programs limited their activities to public awareness campaigns, but are now involved in part-time HIV outreach, intervention, and referral activities for high risked persons.

School and College Age Youth

Limited data suggest that American Indian and Alaska Native youth continue to engage in unprotected sex at an early age. Surrogate data such as teen pregnancy and STD rates support this position. IHS provides AIDS

Prevention/Risk Reduction services to all reservation-based schools, school boards, and educators, as well as Teen Clinics, Youth Substance Abuse Treatment Centers, and other youth organizations. Regular training sessions are offered to the Bureau of Indian Affairs school administrators, teachers, and school board members. IHS personnel are participating in school health programs and curriculum development.

Local Programs - Community Awareness

The IHS has provided AIDS Prevention/Risk Reduction services to all AI/AN communities. Nearly all of the IHS service population has heard or seen an AIDS education message. Communities have established local task forces to encourage greater community involvement and to assist lifestyle changes.

Health Care Workers

The local service units maintain continuing medical education programs on HIV prevention for all health care workers. The IHS also provides training on universal precautions and implementation of Center for Disease Control ACTG Protocol 076 to prevent transmission of HIV from infected mothers to uninfected newborn.

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ACTIVITY/MECHANISMS BUDGET SUMMARY
Department of Health and Human Services
Indian Health Service - 75-0390-0-1-551
INFORMATION TECHNOLOGY INFRASTRUCTURE

Program Authorization: Program authorized by 25 U.S.C. 13, Snyder Act, P.L. 83-568, Transfer Act 42 U.S.C. 2001, and P.L. 102-573, Title II, Section 214.

	2001 Actual	2002 Appropriation	2003 Estimate	Increase Or Decrease
Current Law BA	$51,998,000	$56,498,000	$58,998,000	$2,500,000
Accrued Cost	0	0	0	0
Proposed Law BA	$51,998,000	$56,498,000	$58,998,000	$2,500,000

NOTE: These budget amounts are included in the Hospitals & Clinics and Direct Operations Sub Sub Activity.

PURPOSE AND METHOD OF OPERATION

Information technology (IT) is essential to efficient resource management and effective health care delivery in the Indian Health Service. The Indian Health Service (IHS) IT infrastructure includes people, computers, and communications capability that support every aspect of the IHS mission. The IHS IT is based on an architecture that incorporates government and industry standards for the collection, processing, and transmission of information. IHS IT is managed as a strategic investment by senior management. The IHS IT is fully integrated with the agency's programs and is critical to improving service delivery.

Program Mission and Responsibilities

The **Resource and Patient Management System (RPMS)** is a decentralized automated information system consisting of over 60 software applications. The system is designed to operate on micro and mini-computers located at over 400 IHS, tribal, urban Indian health and public health nursing sites/facilities. RPMS software modules fall into three major categories: patient-based administrative applications, patient-based clinical applications, and financial and administrative applications.

The patient-based administrative and clinical applications support the direct delivery of health care in IHS. The patient-based administrative applications include software that performs patient registration, scheduling, billing, and interface functions. The patient-based clinical applications include packages that support the various health care programs including immunization, laboratory, pharmacy, radiology, and diabetes. These patient-based applications are highly integrated. This allows the RPMS to store patient data in a core set of centralized files rather than in a number of discipline-specific or program-specific files. The IHS Division of Information Resources (DIR) maintains a centralized data warehouse for patient encounter and administrative data. Through the wide-area network (WAN) each health care facility sends select information about patient encounters to the national data repository. The national database

is used to provide reports for statistical purposes; performance measurement for GPRA and accreditation; public health and epidemiological studies.

The IH continues to develop and improve existing health information systems. Projects that are presently underway are electronic data interchange and code sets required by the HIPAA regulations; development and deployment of provider order-entry to promote patient safety; Point-of-Sale pharmacy billing to improve collections and decrease time to billing; and improved generic interface systems (GIS) to allow data exchange with the Health Care Financing Administration and the States (for immunization registries).

The IHS **telecommunications infrastructure** connects IHS, tribal, and urban (I/T/U) facilities together and to the national data repository. This infrastructure is used for data transmission, voice traffic, and Intranet/Internet access. The capacity to support expanding data transmission as well as new telehealth applications will require increased overall capacity. The need to improve security and better manage the infrastructure is being addressed through deployment of regional firewalls to improve network security; activation of the national antivirus gateway to prevent email borne computer viruses; deployment of a national Virtual Private Network to provide IHS business partners and employees a secure method for remotely accessing IHS network resources; and the installation of Enterprise Information Management tools such as Peregrine's Infotools (IND and IDD) to improve management of the network.

The RPMS financial and administrative applications include software that automates financial, billing, and equipment inventory/repair processes. These applications support third party revenue generation, national equipment inventories reporting, and provide information for the development of the IHS budget. However, non-RPMS applications such as material, financial and personnel management systems are not fully integrated. IHS will continue efforts to integrate RPMS systems with other commercial and governmental applications through the use of current technology. This will allow IHS to improve business practices through cost reporting, enhanced revenue generation, cost containment, and work efficiencies and benchmarking comparisons.

Overall IHS seeks to improve the IT infrastructure through: improvements to data quality, accuracy and precision through upstream edits and user tools; improved architecture of the database; and direct user access for epidemiologists, statisticians and other health professionals to provide health care trend analysis.

The DIR develops and tests new software and then distributes the RPMS application suite to IHS Headquarters, Area Offices and other federal partners. Each Area Office releases the RPMS application suite to the appropriate hospitals, clinics, health aid, and State public health nursing sites

The IHS participates in an on-going joint effort with the Department of Veterans Affairs in the development of software and sharing of technology resources. Recently, this federal health care collaboration has been expanded to include the Department of Defense. This collaboration is reflected in the IHS IT Architecture and the IHS five-year plan.

ACCOMPLISHMENTS

Through improvements in IT systems and infrastructure, IHS continues to more effectively measure GPRA performance indicators and meet reporting requirements. The IHS has already realized benefits from our efforts to update and improve our data systems. Data for three indicators (indicators 6, 7, and 27), that earlier in FY 2000 were dependent on manual assessment through chart audits, have recently been successfully extracted from our electronic patient records systems as an evaluation sample. Based on this new capability, the chart audit originally planned as the primary approach for assessing these indicators will be used as a verification process for the electronic approach. Another positive spin-off of these emerging IT capabilities is the addition of a newly proposed performance indicator for FY 2001 and FY 2002 (Indicator 17) that further expands the automated extraction of GPRA clinical performance measures by developing test sites to assess and improve data quality. Included in this innovative project are efforts to adopt recognized data standards for laboratory and other data that are now uniformly accepted by most of the healthcare industry. This project is also developing web-based training to support the efficient diffusion of newly developed technologies across the IHS.

Steps are underway to improve the quality and completeness of data. This has been and is a challenging process requiring a high level of coordination and cooperation between the local I/T/Us, Areas and Headquarters. The combination of improvements in the IT architecture and program operations will ultimately improve the quality and availability of data. Current efforts are focused on securing data for indicator 26 (not yet reported) and on final data validation and verification for six other indicators (Indicators 1, 6-8, 13 and 22). We are confident these efforts will be realized in the near future and we remain committed to improving the processes for generating and making GPRA and other accountability data a major focus of our IT development path.

PERFORMANCE PLAN

The following performance indicators are included in the IHS FY 2003 Annual Performance Plan. These indicators address the development of improved automated data capabilities that support clinical care and performance measurement. At this funding level, IHS will be able to achieve the following in FY 2003:

Indicator 17: During FY 2003, IHS will:

- Complete collection of baseline data for any performance measures where electronic data collection was implemented in FY 2002 and continue collection into measurement years,
- Implement additional electronically derived performance measures as their accuracy is proven to be sufficient,
- Distribute semi automated LOINC mapping tool for IHS' clinical information system to all (100 percent) I/T/U sites; achieve full local LOINC mapping at 5 sites in addition to the 5 pilot sites.

Indicator 18: During FY 2003, increase the number of I/T/U programs utilizing the Mental Health/Social Services (MH/SS) data reporting system by 5 percent over the FY 2002 rate.

Indicator 19: During FY 2003, increase by 10 percent the proportion of Urban Indian health care programs that have implemented mutually compatible automated information systems which capture health status and patient care data over the FY 2002 level.

Following are the funding levels for the last 3 fiscal years:

Year	Funding
2000	$56,120,000
2001	$51,998,000
2002	$56,498,000

RATIONALE FOR BUDGET REQUEST

Total Request -- The request of $58,998,000 is a net increase of $2,500,000 over the FY 2002 enacted level of $56,498,000 for information technology. The net increase includes the following:

Program Increase: +$2,500,000

The program increase will provide departmental level funding to partially meet the IHS contribution to the HHS Information Technology Strategic Five Year Plan to strengthen critical IT infrastructure.

ACTIVITY/MECHANISMS BUDGET SUMMARY
Department of Health and Human Services
Indian Health Service - 75-0390-0-1-551
EPIDEMIOLOGY CENTERS

Program Authorization:
Program authorized by 25 U.S.C. 13, Snyder Act, P.L. 83-568, Transfer Act 42 U.S.C. 2001, and P.L. 102-573, Title II, Section 214.

	2001 Actual	2002 Appropriation	2003 Estimate	Increase or Decrease
A. Current Law BA	$1,450,000	$1,450,000	$2,950,000	+$1,500,000
B. Accrued costs	0	0	0	0
C. Proposed Law BA	$1,450,000	$1,450,000	$2,950,000	+$1,500,000

NOTE: These budget amounts are included in the Hospitals & Clinics Sub-Activity.

PURPOSE AND METHOD OF OPERATION

Although acquisition of medical data through development of information systems is critical, just as important is the ability to analyze and interpret the data. Because most medical data are complex, simple reports automatically generated by computer systems cannot answer many questions posed by health professionals and administrators. Trained epidemiologists are needed to complete the system of health information for tribes and communities.

The innovative Tribal Epidemiology Center program was authorized by Congress as a way to provide significant support to multiple tribes in each of the IHS Areas. Beginning in FY 1996, four Centers were funded up to $155,000 each. Since then, these centers have proven that the concept is sound and worthy of additional funding and expansion of the program. In response to a Request For Proposal in FY 2000, the four original centers were funded for another five years, and two new centers were funded. The annual level of funding for FY 2002 will be approximately $207,000 for each center. This primary source of increased funding was a $500,000 increase in FY 2001 earmarked for HIV research.

Operating from within tribal organizations such as regional health boards, the Epidemiology centers are uniquely positioned to be effective in disease surveillance and control programs, and also in assessing the effectiveness of public health programs. In addition, they can fill gaps in data needed for Government Performance and Results Act and Healthy People 2010. Some of the four existing Epidemiology Centers have already developed innovative strategies to monitor the health status of tribes, including development of tribal health registries, and use of sophisticated record linkage computer software to correct existing state data sets for racial misclassification. These data may then be collected by the National Coordinating Center at the IHS Epidemiology Program to provide a more accurate national picture of Indian Health.

EPI CENTERS		
Northwest Portland Epi Center	Inter-Tribal Council of Arizona Epi Center	Alaska Native Epi Center
Great Lakes Inter-Tribal Epi Center	Seattle Indian Health Epi Center	United South and Eastern Tribes, Inc. Epi Center

Epidemiology Centers provide critical support for tribal efforts at self-governing of health programs. Data generated locally and analyzed by Epidemiology Centers enable Tribes to evaluate tribal and community-specific health status data so that planning and decision making can best meet the needs of their tribal membership. Because these data are used at the local level, immediate feedback is provided to the local data systems which will lead to improvements in Indian health data overall. They also can assist tribes in activities such as conducting Behavioral Risk Factor Surveys in order to establish baseline data for successfully evaluating intervention and prevention activities. Epidemiology centers can assist tribes in looking at the cost of health care for Indian people in order to improve the use of resources. In the future, in the expanding environment of tribally operated health programs, epidemiology centers will ultimately provide additional public health services such as disease control and prevention programs. Some existing centers already provide assistance to tribal-participants in such areas as sexually transmitted disease control and cancer prevention.
In FY 2003, this Program will continue to enhance the ability of the Indian health system to collect and manage data more effectively to better understand and develop the link between public health problems and behavior, socioeconomic conditions, and geography.

The Tribal Epidemiology Program will also support tribal communities by providing technical training in public health practice and prevention-oriented research and promoting public health career pathways for tribal members.

Efforts to implement the Tribal Epidemiology Program will be coordinated with the Centers for Disease Control and Prevention (CDC) to optimize federal resource utilization, create stronger interagency partnerships, and prevent costly duplication of effort.

Funding for the Epidemiology Centers program during the last five years has been as follows:

Year	Funding
1998	
1999	$750,000
2000	$950,000
2001	$1,450,000
2002	$1,450,000

RATIONALE FOR BUDGET REQUEST

Total Request -- The request of $2,950,000 is an increase of $1,500,000 over the FY 2002 enacted level of $1,450,000. The increase is as follows:

Epidemiology Center: +$1,500,000

There is growing consensus among Tribes that the regional Epidemiology Centers could provide support for a variety of public health activities that IHS is no longer able to provide. The proposed $1,500,000 funding increase will enable existing epidemiology centers and newly established centers to more adequately fulfill their mission of providing service to tribal communities in their regions. A fully staffed center should be composed of at least one physician or doctoral-level epidemiologist, two Masters-level epidemiologists, and a statistician. For this size of staff, with travel and office support, approximately $500,000 is needed for each center. New funds would allow IHS to add one new epidemiology center in another region, as well as move closer to that target level of base funding for each of the six existing centers.

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ACTIVITY/MECHANISM BUDGET SUMMARY
Department of Health and Human Services
Indian Health Service - 75-0390-0-1-551
Preventive Health

Program Authorization: Program authorized by 25 U.S.C. 13, Snyder Act and P.L. 83-568, Transfer Act 42 U.S.C. 2001.

	2001 Actual	2002 Appropriation	2003 Estimate	Increase Or Decrease
A. Current Law BA	$95,709,000	$99,724,000	$103,268,000	+$3,544,000
B. Accrued Cost 1/	1,705,00	1,865,000	1,984,000	119,000
C. Proposed Law BA	$97,414,000	$101,589,000	$105,252,000	+$3,663,000
HIV/AIDS	($535)	($535)	($535)	($0)
FTE	305	313	325	+12
HIV/AIDS	(1)	(1)	(1)	(0)

1/ Please see Exhibit S for the crosswalk from current law to proposed law to reflect the Administration's proposal for full accrued retirement and health benefits.

Total Request Level -- The total request of $105,252,000 (including accrued costs of $1,984,000) and 325 FTE is an increase of $3,663,000 and 12 FTE over the FY 2002 enacted level of $99,724,000 plus accrued cost of $1,865,000 and 313 FTE. The explanation of the request is described in the activities that follow.

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PUBLIC HEALTH NURSING

Indian Health Service

Preventive Health	2001 Actual	2002 Appropriation	2003 Estimate	Increase Or Decrease
Public Health Nursing				
A. Current Law BA	$36,114,000	$37,781,000	$39,875,000	+$2,094,000
B. Accrued Costs 1/	1,532,000	1,663,000	1,764,000	+101,000
C. Proposed Law BA	$37,646,000	$39,444,000	$41,639,000	+$2,195,000
D. FTE	274	279	289	+10
E. No. Of Pt. Visit	370,048	376,048	376,048	0
F. No. Of PHN Home Visits Provided	126,373	128,000	128,000	0

1/ Please see Exhibit S for the crosswalk from current law to proposed law to reflect the Administration's proposal for full accrued retirement and health benefits.

PURPOSE AND METHOD OF OPERATION

Program Mission/Responsibilities

The IHS Public Health Nursing (PHN) is the integration of nursing practice and public health practice, applied to the prevention of disease and the promotion and preservation of the health of the American Indian population. PHN services are provided to individuals, families, groups which contribute to the health of the community.

The majority of AI/AN live in rural and isolated communities and access to modern convenience such as telephone and transportation are not necessarily available to access medical care. Access to medical care is also a challenge for some AI/AN members who live in urban areas and often the PHN is the link to health care in these remote communities or isolated urban settings.

The PHN is one of the most visible and well-known programs to the American Indian tribes because it is entirely community based. Their services are based on the assessed needs of the individuals, families, groups, and communities. The PHN role is one of health education, strengthening relationships with the Indian community and providing the framework for broadly based community efforts, which include: therapy, counseling, education, and coordination of care by referring clients to other disciplines and case management activities. The Public Health Nurse collaborates with members of the health care team to deliver the required services.

Best Practices/Industry Benchmark

The PHN program is an integral component in the Indian Health Service/Tribal/Urban (ITU) health programs. The tribes operate

approximately one third of the PHN programs. Outreach activities include: home visits, well child examination in remote communities, immunizations, prenatal care and follow up visits for skilled nursing services such as daily dressing changes or assist families with home Intravenous chemo-therapy. Home visits continue to be a mainstay of the PHN activities along with case finding which together accounts for over 50 percent of the PHN time. Another 20 percent of the PHNs time is spent in activities for children under the age of 5 years. This is a collaborative effort with the Maternal and Child Health (MCH) team.

Because the PHNs are community based their coordination of care includes STIs, health counseling, and education on FAS/FAE. Community assessment and developing population based plans of care are another important PHN activity. Collaboration with State and county agencies to plan appropriate programs to meet the needs of the Indian community often requires input from the I/T/U PHNs.

Findings Influencing FY 2003 Request

PHN services related to preventive care are directly influenced by PHN home visits, including Prenatal care, high immunization rates, post hospitalization home visits for skilled and unskilled nursing services.

The IHS service population is increasing at a rate of about 2 percent per year. The health needs of the growing elder population are increasing at 15 percent of the PHNs home visits. There is increasing emphasis to address the health disparities that are identified for the AI/NA population.

Public Health Nursing continues to work to eliminate health disparities. Some AI/AN women have higher rates of cervical cancer. PHNs make home visits to educate at risk women and encourage early screening and follow up to missing appointments.

AI/AN have higher incidence and prevalence of diabetes mellitus and its complications. PHNs conduct home visits to educate the importance of glycemic control to delay the onset of complications based on a plan of care. Hypertension and heart disease are often co-existing conditions with diabetes forcing resources to be channeled into tertiary interventions.

PHNs collaborate with other members of the Maternal and Child Care team to improve health outcome for the mother and child. AI/AN is a young population, greater than 50 percent of its population is in the childbearing years. PHNs make home visits to increase first prenatal visits in the first trimester. Home visits are made to those prenatal patients who have risk factors such as smoking, alcohol and drug use in pregnancy which correlate with poor outcome for the baby. There is documentation that mothers and their children who receive PHN home visits have better outcomes (Olds et.al., 1998). In FY 2000, 39 percent of the PHNs services were to maternal, child health promotion.

Pockets of AI/AN continue to experience incidences of infectious disease, such as Tuberculosis and Hantavirus, which require stringent investigation of the environment and education on prevention.

Some of the PHN programs have successfully passed accreditation by the National League for Nursing, while many programs have chosen not to continue this accreditation process due to varying funding priorities. In FY 2003, IHS will continue to work with PHN programs on accreditation so that the PHN programs could continue to meet national standards.

ACCOMPLISHMENT

Fiscal year 2000 there was an increase of 2.5 million dollars. This increase allowed 18 IHS and 17 tribal programs to expand their services. These expanded services included access to the PHNs for neonates, infants, women, elder and 6 Tribal programs have been able to provide PHN services for the first time for their population.

PERFORMANCE PLAN

The FY 2003 funding request for Public Health Nursing will contribute to the accomplishment of the following performance indicators, which are included in the IHS FY 2003 Annual Performance Plan.

Indicator 2: During FY 2003, maintain the FY 2002 performance level for glycemic control in the proportion of I/T/U clients with diagnosed diabetes.

Indicator 3: During FY 2003, maintain the FY 2002 performance level for blood pressure control in the proportion of I/T/U clients with diagnosed diabetes who have achieved blood pressure control standards.

Indicator 6: During FY 2003, maintain the proportion of eligible women who have had a Pap screen within the previous three years at the FY 2002 levels.

Indicator 7: During FY 2003, maintain mammography screening at the FY 2002 rate.

Indicator 8: During FY 2003, maintain the proportion of AI/AN children served by IHS receiving a minimum of four well-child visits by 27 months of age at the FY 2002 level.

Indicator 22: During FY 2003, maintain the total number of public health nursing services (primary and secondary treatment and preventive services) provided to neonates, infants, and elders in all settings and the total number of home visits at the FY 2002 workload levels.

Indicator 23: In FY 2003, maintain FY 2002 levels in the proportion of AI/AN children who have completed all recommended immunizations for ages 3-27 months, as recommended by Advisory Committee on Immunization Practices.

Indicator 24: During FY 2003, maintain FY 2002 influenza vaccination rates among non-institutionalized adults aged 65 years and older.

Funding for the Public Health Nursing program during the last five years has been as follows:

Year	Funding	FTE
1998	$28,198,000	289
1999	$30,363,000	284
2000	$34,452,000	287
2001	$37,646,000	274
2002	$37,781,000	279

RATIONALE FOR BUDGET REQUEST

TOTAL REQUEST -- The request of $41,639,000 (including accrued costs of $1,764,000) and 289 FTE is an increase of $2,195,000 and 10 FTE over the FY 2002 enacted level of $37,781,000 plus accrued cost of $1,663,000 and 279 FTE. The increases include the following:

Pay Cost Increases: +$864,000

The request of $864,000 for Federal and Tribal pay costs would fund increases associated with on-going operations.

The IHS continues to strive to increase access for the IHS patient population. Maintaining the current I/T/U health system by ensuring access and continuity of care is necessary in eliminating disparities in health status between AI/AN and the rest of the U.S. population.

Phasing-In of Staff for New Facilities: +$1,331,000 and 10 FTE

The request of $1,331,000 and 10 FTE provides for the phasing-in of staff and related costs for new facilities. The staffing of new facilities also contributes to the recruitment and retention of medical staff and promotes self-determination activities. The following table displays the requested increase.

Facilities:	**Dollars**	**FTE**	**Tribal**
Ft. Defiance, AZ Hospital	$ 798,000	9	0
Parker, AZ Health Center	89,000	1	0
Winnebago, NE Hospital	444,000	0	5
Total	$1,331,000	10	5

Accrued Retirement and Health Benefits Costs

The increase of $101,000 is associated with the proposed Managerial Flexibility Act of 2001; **the full accrued cost in FY 2003 for Public Health Nursing is $1,764,000.** This legislation requires agencies, beginning in FY 2003, to pay the full Government share of the accruing cost of retirement for current CSRS, CIA and Foreign Service employees, and the Coast Guard, Public Health Service and NOAA Commissioned Corps. The legislation also requires agencies to the pay full accruing cost of post-retirement health benefits for current civilian employees. The intention of the legislation is to budget and present the full costs of Federal employees in the accounts and programs where they are employed.

This legislation is part of an initiative to link budget and management decisions to performance by showing the full cost of each year's program operations together with the output produced that year. These accrual costs are shown comparably in FY 2001 and FY 2002.

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HEALTH EDUCATION

Indian Health Service

Preventive Health Health Education:	2001 Actual	2002 Appropriation	2003 Estimate	Increase or Decrease
A. Current Law BA	$10,063,000	$10,628,000	$11,063,000	+$435,000
B. Accrued Costs 1/	173,000	202,000	220,000	+18,000
C. Proposed Law BA	$10,236,000	$10,830,000	$11,283,000	+$453,000
HIV/AIDS	($535,000)	($535,000)	($535,000)	0
FTE	31	34	36	+2
(HIV/AIDS FTE)	(1)	(1)	(1)	(0)
Health Educ. Svcs Provided	600,000	600,0000	600,000	0

1/ Please see Exhibit S for the crosswalk from current law to proposed law to reflect the Administration's proposal for full accrued retirement and health benefits.

PURPOSE AND METHOD OF OPERATION

Program Mission and Responsibilities

The IHS Health Education Program is committed to a partnership with American Indian and Alaska Native (AI/AN) communities to raise the health status of AI/AN to the highest possible level. This is accomplished through education, leadership and promoting community capacity building that nurtures healthy lifestyles and utilization of health services. In addition, the Health Education Program fosters participation of AI/AN communities in developing and managing programs to meet their health priorities.

The emphasis of the IHS Health Education is to strategically improve and strengthen the practice of public health education, to take an active role in community health planning as determined by sound epidemiological data. The IHS Health Education adheres to proven intervention strategies that are driven by community-based priorities identified by local communities. The Health Education Program has identified these priorities that encompass the core practices of public health education - community health, school health, employee health promotion, and patient education:

- To provide leadership in developing safe and healthy Indian communities.
- To develop and strengthen a standardized, nationwide patient education program.
- To enhance the capacity of those schools that educate American Indians and Alaskan Natives to respond to threats to youth health.

- To assist Head Start programs in the provision of health education activities.

- To support the IHS Director's youth, elderly and women's priorities.

- To support diabetes education.

- To accomplish these activities, partnerships have been developed with health programs, tribes, schools, communities, educational institutions, public and private foundations. The IHS Health Education program will assist our partners to engage in community-based prevention activities, such as smoking cessation, diabetes education, HIV/AIDS/STD risk behavior education, injury prevention, obesity and physical inactivity, and hearing loss.

The Health Education Program has been active through the development and completion of a Web site that includes Health Education recruitment information, the IHS Patient Education Protocols/Codes, and a directory of all I/T/U health education programs. In addition, the Program has designed and implemented a new aspect to the Health Education Resource Management System (HERMS) that automatically translates raw monthly HERMS data into more user friendly forms, such as charts, graphs, etc.

Based on preliminary analyses of FY 2000 health education workload data, approximately 40 percent of the eligible AI/AN population had access to health education services.

A health education services decrease the approach to medicine moves away from a preventive, health and wellness model to one of acute and chronic care.

Best Practices/Industry Benchmarks

The IHS Health Education Program has a long history of serving as a benchmark and Federal model of health education services. It is one of the few health education programs nationally that serves such diverse health education needs working with over 561 tribal entities. Most recently, the program has embarked on a model "Patient Education Project" that allows outcome measurements to be obtained for health education services to meet the new JCAHO standards for health/patient education. New FY 2001 ORYX Indicators have also been developed to track health education in our hospitals, clinics and community programs on breast self-exams, diabetes and exercise, smoking cessation, and breast-feeding.

ACCOMPLISHMENT

The IHS Health Education program continues the development and implementation of a standardized, nationwide patient education program. During FY 2001, approximately 500,000 patient education encounters were documented on the IHS RPMS/PCC system.

To enhance the capacity of schools, Head Start and tribal education programs educate American Indians and Alaskan Natives to respond to threats to youth health. The IHS Health Education program has renewed and increased our efforts to work with, and to develop health education

programs in partnership with the Bureau of Indian Affairs, the US Department of Education and the IHS Head Start Program.

Health Education is assisting the IHS Nutrition program to effect changes in youth obesity rates through school health education programs that target nutrition education and physical education.

Health Education is assisting three AI/AN communities to implement culturally sensitive community-directed pilot cardiovascular disease prevention programs.

To support diabetes education, the IHS Health Education program, through the IHS Patient and family education project, is working with the IHS Diabetes Program to track all diabetes education being provided in I/T/Us hospitals and clinics. FY 2001 diabetes education statistics indicate that 48,000 diabetes education encounters were documented on the IHS PRMS/PCC system.

To accomplish these activities, partnerships have been developed with other governmental agencies such the as National Institutes of Health - Heart, Blood and Lung Institute, the National Institute of Hearing Disorders; the Health Care Finance Administration; the Bureau of Indian Affairs; and other IHS programs such as the IHS Pharmacy Program and the IHS Community Health Representative Program.

PERFORMANCE PLAN

The FY 2003 funding request for Health Education will contribute to the accomplishment of the following performance indicators, which are included in the IHS FY 2003 Annual Performance Plan.

Indicator 2: During FY 2003, maintain the FY 2002 performance level for glycemic control in the proportion of I/T/U clients with diagnosed diabetes.

Indicator 3: During FY 2003, maintain the FY 2002 performance level for blood pressure control in the proportion of I/T/U clients with diagnosed diabetes who have achieved blood pressure control standards.

Indicator 6: During FY 2003, maintain the proportion of eligible women who have had a Pap screen within the previous three years at the FY 2002 levels.

Indicator 7: During FY 2003, maintain mammography screening at the FY 2002 rate.

Indicator 23: In FY 2003, maintain FY 2002 levels in the proportion of AI/AN children who have completed all recommended immunizations for ages 3-27 months, as recommended by Advisory Committee on Immunization Practices.

Indicator 24: During FY 2003, maintain FY 2002 influenza vaccination rates among non-institutionalized adults aged 65 years and older.

Indicator 26: During FY 2003, assure that the unintentional injury-related mortality rate for AI/AN people is no higher than the FY 2002 level.

Indicator 28: During FY 2003, the IHS will continue collaboration with NIH to assist three AI/AN communities to implement culturally sensitive community-directed pilot cardiovascular disease prevention programs and initiate expansion into at least one new AI/AN site.

Funding for the Health Education program during the last five years has been as follows:

Year	Funding	FTE
1998	$8,932,000	43
1999	$9,430,000	37
2000	$9,625,000	35
2001	$10,236,000	31
2002	$10,628,000	34

RATIONALE FOR BUDGET REQUEST

Total Request -- The request of $11,283,000 (including accrued costs of $220,000) and 36 FTE is an increase $453,000 and 2 FTE over the FY 2002 enacted level of $10,628,000 plus accrued cost of $202,000 and 34 FTE. The increase includes the following:

Pay Cost Increases: +$269,000

The request of $269,000 for Federal and Tribal pay costs would fund increases associated with on-going operations.

The IHS continues to strive to increase access for the IHS patient population. Maintaining the current I/T/U health system is necessary in eliminating disparities in health status between AI/AN and the rest of the U.S. population.

Phasing-In of Staff for New Facilities: +$184,000 and 2 FTE

The request of $184,000 and 2 FTE provides for the phasing-in of staff and related costs for new facilities. The staffing of new facilities also contributes to the recruitment and retention of medical staff and promotes self-determination activities.

The following table displays the requested increase.

Facilities:	**Dollars**	**FTE**
Ft. Defiance, AZ Hospital	$184,000	2

Accrued Retirement and Health Benefits Costs

The increase of $18,000 is associated with the proposed Managerial Flexibility Act of 2001; the full accrued cost in FY 2003 for Health Education is $220,000. This legislation requires agencies, beginning in

FY 2003, to pay the full Government share of the accruing cost of retirement for current CSRS, CIA and Foreign Service employees, and the Coast Guard, Public Health Service and NOAA Commissioned Corps. The legislation also requires agencies to the pay full accruing cost of post-retirement health benefits for current civilian employees. The intention of the legislation is to budget and present the full costs of Federal employees in the accounts and programs where they are employed. This legislation is part of an initiative to link budget and management decisions to performance by showing the full cost of each year's program operations together with the output produced that year. These accrual costs are shown comparably in FY 2001 and FY 2002.

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COMMUNITY HEALTH REPRESENTATIVES (CHR)

Indian Health Service

Preventive Health	2001 Actual	2002 Appropriation	2003 Estimate	Increase or Decrease
Community Health Representatives:				
A. Current Law BA	$48,061,000	$49,789,000	$50,774,000	+$985,000
B. Accrued costs	0	0	0	0
C. Proposed Law BA	$48,061,000	$49,789,000	$50,774,000	+$985,000
D. Number of CHRs	1,612	1,612	1,612	0
E. # of Tribally Operated Svcs. Provided	2,200,000	2,200,000	2,200,000	0

PURPOSE AND METHOD OF OPERATION

Program Mission/Responsibilities

As tribally contracted and compacted programs, the 215 Community Health Representative (CHR) programs are tribally administered outreach programs. They are based on the concept that American Indian/Alaska Native (AI/AN) community members, trained in the basic skills of health care provision, disease control, and prevention, can successfully create change in community acceptance and utilization of Western health care resources. The Indian Health Service works with tribes and provides leadership and guidance to the CHR program.

The CHR Program plays an important role in the successful implementation of IHS/Tribal health promotion/disease prevention initiatives and efforts to improve access to medical services. The CHR are indigenous people well positioned within their communities to provide the needed educational and related services that can result in healthier lifestyles and early treatment and lower morbidity among their people. The CHR are proven effective outreach health care providers and have established an efficient network system through which health promotion/disease prevention and health care access are being delivered to the AI/AN people.

ACCOMPLISHMENT

The Community Health Representative program has developed two reporting methods to record the services provided by CHRs, the RPMS/PCC Direct and the RPMS/PCC Remote Reporting. CHRs made approximately 3.0 million client-patient contacts annually. A total of 1.5 million service hours are spent on health education, case management, patient care, case finding, monitoring, and transporting patients needing care in the health areas of diabetes, hypertension, health promotion/disease prevention, alcohol/substance abuse, cancer, communicable diseases.

The Community Health Representative Program launched a new CHR Web Site that provides access to a CHR Newsletter; the ability to download local and regional reports from the RPMS/PCC Direct and the RPMS/PCC Remote Reporting; and, other important information about the CHR program.

The CHR Program provides 3-Week CHR Basic training sessions to assist Community Health Representatives to obtain a health and medical education appropriate to the CHR program. The CHR program also provides CHR Refresher training sessions for those CHR staff that have been employed by the local CHR program for more than two-years. The CHR Program recently revised the 3-Week Basic training manual as well as revised the CHR Refresher training manual.

The Community Health Representative Program continues to maintain a close working relationship with the National Association of Community Health Representatives - joining forces to elevate the health status of American Indians and Alaskan Natives to the highest possible.

PERFORMANCE PLAN

The FY 2003 funding request will contribute to the accomplishment of the following performance indicators, which are included in the FY 2003 Annual Performance Plan.

Indicator 2: During FY 2003, maintain the FY 2002 performance level for glycemic control in the proportion of I/T/U clients with diagnosed diabetes.

Indicator 23: In FY 2003, maintain FY 2002 levels in the proportion of AI/AN children who have completed all recommended immunizations for ages 3-27 months, as recommended by Advisory Committee on Immunization Practices.

Indicator 24: During FY 2003, maintain FY 2002 influenza vaccination rates among non-institutionalized adults aged 65 years and older.

Funding for the Community Health Representatives program during the last five years has been as follows:

Year	Funding	FTE
1998	$44,312,000	13
1999	$45,960,000	5
2000	$46,380,000	0
2001	$48,061,000	0
2002	$49,789,000	0

RATIONALE FOR BUDGET REQUEST

TOTAL REQUEST -- The request of $50,774,000 is an increase of $985,000 over the FY 2002 enacted level of $49,789,000. The increase includes the following:

Pay Cost Increases: +$959,000

$959,000 for tribal pay costs.

The IHS continues to strive to increase access for the IHS patient population. Maintaining the current I/T/U health system is necessary in eliminating disparities in health status between AI/AN and the rest of the U.S. population.

Phasing-In of Staff for New Facilities: +$26,000

$26,000 provides for the phasing-in of staff and related costs for new facilities. The staffing of new facilities also contributes to the recruitment and retention of medical staff and promotes self-determination activities.

The following table displays the requested increase.

Facilities:	**Dollars**	**FTE**	**Tribal**
Winnebago, NE Hospital	$26,000	0	1

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HEPATITIS B AND HAEMOPHILUS IMMUNIZATION PROGRAMS (ALASKA)

Indian Health Service

Preventive Health	2001 Actual	2002 Appropriation	2003 Estimate	Increase or Decrease
Hepatitis & Haemophilus Influenza Immunization Program (Alaska)				
A. Current Law BA	$1,471,000	$1,526,000	$1,556,000	+$30,000
B. Accrual Costs 1/	0	0	0	0
C. Proposed Law BA	$1,471,000	$1,526,000	$1,556,000	+$30,000
Services Provided IHS Operated:				
*# hepatitis patients given clinical care	2,900	2,900	2,900	2,900
# chronic carriers surveyed.....	1,482	1,492	1,492	1,492
** patients immunized:				
# Hepatitis A/B....	8,400	8,400	8,400	8,400
# Hepatitis C patients followed..	800	900	900	900
•Evaluate long-term protection of Hep. A vaccine.....	400	400	400	400
•Evaluate need for Hep. B booster doses:				
Infants/Children.....	1,982	1,982	1,982	1,982
Adults.....	3,000	3,000	3,000	3,000
Immunization Records Audited:.....	3,000	3,000	3,000	3,000
# Trained in RPMS software:.....	75	90	90	90
***Purchases of vaccine (adult): Hepatitis A...	$50,000	$50,000	$50,000	$50,000
Hepatitis B...	$50,000	$50,000	$50,000	$50,000

*These patients have diagnostic exams and procedures performed by hepatitis program staff at rural field clinics and at Alaska Native Medical Center.
**These figures represent patients immunized in hepatitis A/B studies, and adult vaccination with program-purchased vaccine. Changes in figures represent hepatitis A vaccination of adults with chronic hepatitis C infection.
Individual Native tribal corporations and State Public Health Nurses provide Childhood vaccines, including Hib vaccine.
***These figures represent the purchase of adult Hepatitis A and B vaccines agreed upon in the Alaska compacting tribes funding agreement with IHS. Hepatitis B vaccine is offered to any susceptible Alaska Native adult. Hepatitis A vaccine is offered to non-immune adults in high-risk groups.

1/ Please see Exhibit S for the crosswalk from current law to proposed law to reflect the Administration's proposal for full accrued retirement and health benefits.

PURPOSE AND METHOD OF OPERATION

The Viral Hepatitis Program (Hepatitis B Program) and the Immunization (Hib) Program are distinct programs of the Alaska Native Tribal Health Consortium (ANTHC).

Tribal Contracts:	
Bristol Bay Health Corps	$ 133,000
Yukan Kuskokwin Health Corp.	228,500
Total:	$ 361,500

Tribal Shares: The 2003 budget is 100 percent tribal-administered in the Alaska Tribal Health Compact, and an agreement by Annual Funding Agreement to support the activities and personnel described below:

Hib Immunization	$ 295,000
Hepatitis	840,400
Total	$1,135,400
TOTAL Tribal Contracts and Shares	$1,496,900

Viral Hepatitis Program

The objective of the Viral Hepatitis Program is to deliver comprehensive hepatitis A, B and C control services to Alaska Natives. The Hepatitis B Program began in 1982 to stop the spread of hepatitis B in Alaska Natives by mass immunization, and to prevent premature death in chronically infected persons by early liver cancer detection. Since 1990 the Program has expanded to include control of hepatitis A infection, detection and control of hepatitis C infection, and identification and research into non-A, B, C, hepatitis infection.

Current activities of the Viral Hepatitis Program include:

- provision of hepatitis B vaccine for susceptible Alaska Native adults, and new Alaska IHS employees,
- continuation of four long-term immunogenicity and efficacy studies to determine when booster hepatitis B vaccine doses are planned,
- surveillance of 1,500 chronic hepatitis B carriers twice yearly for early liver cancer detection (detecting 34 patients with hepatocellular cancer), and for the development of potentially treatable chronic hepatitis.
- studies on the long-term immunogenicity of hepatitis A vaccine in infants and children and adults,
- Hepatitis A vaccination of high risks Alaska Native adults including those with chronic liver disease and injectable drug users.
- provision of hepatitis A vaccine to 2 to 18 year old children using vaccine provided by the State of Alaska,
- development and administration of a Statewide system of surveillance that assures appropriate care of persons chronically infected with hepatitis C,
- development of anti-viral strategies for hepatitis C infections, including initiating study on 500 adults chronically infected with hepatitis C to determine the clinical course and develop preventive and treatment strategies including the use of anti-viral medications,
- collaboration with other agencies to identify additional hepatitis viruses and develop prevention and treatment strategies,
- provision of hepatitis field clinics in rural areas, and education to health providers and patients,
- studies using new antiviral drugs to treat hepatitis C, and
- Implementation of 3 model "look back" programs to screen persons at high risk for exposure to hepatitis C who had a history of receiving blood products or have used injectable drugs in the past. Program will involve up to 4,000 Alaska Natives.

Hib Immunization Program

The objective of the Haemophilus influenza Type B (Hib) Immunization Program is to provide resources, advocacy, training, immunization tracking and coordination of immunization delivery services among Alaska Native tribal programs in order to achieve and maintain high levels of on-time immunization, required to eliminate Hib and other vaccine-preventable diseases in Alaska Natives. Before the advent of Hib vaccines in the late 1980s, Alaska Natives had record rates of Hib meningitis, 6 - 10 times those of other U.S. populations, with a preponderance of disease in young infants. The Program was implemented to prevent Hib disease in Alaska Native infants with on-time immunization. In 1992 the Program objective was expanded include achieving high on-time immunization levels for all recommended childhood vaccines, at 2, 4, 6, 12, and 24 months of age. With the decrease in Hib disease, pneumococcus has emerged as the most common cause of meningitis and blood infections in Alaska Native infants and children who have a rate of pneumococcal disease 4 times that in non-Alaska Natives. In January 2001, pneumococcal conjugate vaccine was added to the infant vaccine schedule. The Program has educated providers, developed training materials, developed a promotional poster, and updated immunization software to encourage the use of pneumococcal conjugate vaccine.

ACCOMPLISHMENTS

Viral Hepatitis Program

Since its beginnings, in 1982, the Viral Hepatitis Program has reached all the high-risk villages in Alaska and has the potential for eradicating hepatitis B. By 1988, the majority of Alaska Natives were immunized against hepatitis B, if not previously infected. More than 96 percent of Alaska Native newborns receive a dose of hepatitis B vaccine before hospital discharge. The annual incidence of acute symptomatic hepatitis B infection has decreased from 215 per 100,000 prior to 1982, to 5 per 100,000. The 1-year case-fatality rate for primary liver cancer has decreased from 100 percent to 50 percent. Liver function tests were added to the semiannual screening test for liver cancer (AFP) to identify patients with severe asymptomatic hepatitis who could be candidates for newly licensed antiviral medications to prevent end stage liver disease and need for subsequent liver transplantation.

The Viral Hepatitis Program has been recognized as the national and international leader in the prevention and control of viral hepatitis, and communicable disease experts worldwide are monitoring its performance.

Since 1989, the Program has conducted studies on the immunogenicity, safety and efficacy of hepatitis A vaccine in infants and adults. In 1993 the program, in collaboration with the State of Alaska and four regional Native health corporations, conducted a project that demonstrated that one dose of hepatitis A vaccine could halt a large outbreak of hepatitis A. The Program is now conducting studies of the effectiveness of hepatitis A vaccine in infants. Other recent accomplishments include initiation of studies on hepatitis B boosting and long-term immunogenicity of hepatitis A vaccines,

and the development of a cancer detection program for persons chronically infected with hepatitis C. The latter has involved development of a registry of persons with hepatitis C, currently approaching 1000 Alaska Natives, and the development and implementation of a plan to screen Alaska Natives at high risk for hepatitis C (persons who received blood transfusions or had cardiac surgery prior to 1992). The program has contacted the Hepatitis C infected persons twice yearly for AFP testing to detect liver cancer early and liver function tests to identify potential treatment candidates.

Hib Immunization Program

Through expanded immunization tracking in Anchorage the 2-year old immunization rate in Anchorage Alaska Natives increased from 81 percent in 1996 to 94 percent in 2000, while the age-appropriate immunization rate in 3-27 month olds increased from 76 percent to 85-89 percent. The Program continues to provide clinical development, testing and training of the new IHS Immunization software package for the computerized Registration and Patient Management System (RPMS). This package, which provides expanded opportunities for immunization tracking and recall, was completed and released IHS-wide in December 1999 and revised in 2000.

> The Hib Immunization program conducts or reviews audits in 12 Alaska Native regions, which have documented an increase in 2-year old immunization rates in Alaska Natives from 49-73 percent in 1990, to 76-98 percent in 1998-9, with more than 90 percent fully, immunized against Hib disease.

The Program has successfully collaborated with the State in a immunization initiative resulting in a state-wide increase in 2-year-old immunization rates according to the National Immunization Survey from 69 percent in 1996 to 81 percent in 1998 (the Alaska Native immunization rate was 87 percent in 1998). The Program assisted with a finalized American Academy of Pediatrics (AAP) statement on Immunizations for American Indians and Alaska Natives.

The Program collaborated with AIP-CDC in studies that justified to the State of Alaska the need for the use of the Hib vaccine, PedvaxHib®, for the first dose. Since instituting this schedule the number of Hib infections has decreased with most cases occurring in under-immunized infants.

We completed the first phase of a study to evaluate the effect of early RSV hospitalization on development of childhood lung disease and asthma. Preliminary data shows that children hospitalized with RSV are at higher risk for wheezing illnesses and lower respiratory illnesses until at least 4 years of age.

PERFORMANCE PLAN

The FY 2003 funding request for the Alaska Viral Hepatitis (Hepatitis B Program) and the Haemophilus influenza Type B (Hib) Immunization (Hib) Programs will contribute to the accomplishment of the following performance indicator, which is included in the FY 2003 Annual Performance Plan.

Indicator 23: In FY 2003, maintain FY 2002 levels in the proportion of AI/AN children who have completed all recommended immunizations for ages 3-27 months, as recommended by Advisory Committee on Immunization Practices.

Funding for the Alaska Immunization Programs during the last five years has been as follows:

Year	Funding	FTE
1998	$1,328,000	0
1999	$1,367,000	0
2000	$1,402,000	0
2001	$1,471,000	0
2002	$1,526,000	0

RATIONALE FOR BUDGET REQUEST

Total Request -- The request of $1,556,000 is an increase of $30,000 over the FY 2002 enacted level of $1,526,000. The increase includes the following:

Pay Cost Increases: +$30,000

The request of $30,000 for Tribal pay costs would fund increases associated with on-going operations.

The IHS continues to strive to increase access for the IHS patient population. Maintaining the current I/T/U health system is necessary in eliminating disparities in health status between AI/AN and the rest of the U.S. population.

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ACTIVITY/MECHANISM BUDGET SUMMARY
Department of Health and Human Services
Indian Health Service - 75-0390-0-1-551
URBAN HEALTH PROGRAMS

Program Authorization:

Program authorized by Title V, P.L. 94-437, Indian Health Care Improvement Act, as amended.

	2001 Actual	2002 Appropriation	2003 Estimate	Increase or Decrease
Current Law BA	$29,843,000	$30,947,000	$31,528,000	+$581,000
Accrued Costs	84,000	90,000	92,000	+2,000
1/ Proposed Law BA	$29,927,000	$31,037,000	$31,620,000	$583,000
HIV/AIDS	($791,000)	($820,000)	($836,000)	+$16,000
FTE	5	5	5	0

Program Output Data:

Services Provided:				
Medical.....	265,000	265,000	265,000	0
Dental.....	69,000	69,000	69,000	0
Outreach/Comm. Services.....	221,000	221,000	221,000	0
Other.....	186,000	186,000	186,000	0
Total.....	741,000	741,000	741,000	0

1/ Please see Exhibit S for the crosswalk from current law to proposed law to reflect the Administration's proposal for full accrued retirement and health benefits.

PURPOSE AND METHOD OF OPERATION

The 1990 census indicated that 739,108 or 37.7 percent of the total U.S. Indian population lived in Indian areas, and that 1,220,126 or 62.3 percent lived in non-Indian areas. Indian areas include reservations, off-reservation trust lands, Alaska Native Regional Corporations, Alaska Native Village statistical areas.

It should be noted that about 36 percent of the IHS service area population resides in non-Indian areas, since the IHS service area includes the "on or near" reservation counties that comprise the contract health service delivery areas.

The IHS Urban Indian Health Program supports contracts and grants to 34 urban health programs funded under Title V of the Indian Health Care Improvement Act. Approximately 605,000 American Indians are eligible to use Title V Urban Indian health programs. Typically, these clients have

less accessibility to hospitals, health clinics, or contract health services administered by the IHS and tribal health programs.

Studies on the urban AI/AN population documented poor health and revealed limited health care options for most families. Since 1972, the IHS has gradually increased its support for health related activities in off-reservation settings aimed at assisting AI/AN populations to gain access to available health services, and also to develop direct health services when necessary.

In the 1992 amendments to the Indian Health Care Improvement Act, the Congress specifically declared the policy of the Nation "in fulfillment of its special responsibilities and legal obligations to the American Indian people to assure the highest possible health status for Indians and urban Indians and to provide all resources necessary to affect that policy." The IHS addresses this responsibility by funding 34 urban Indian health organizations operating at 41 sites located in cities throughout the United States. Primary care clinics and outreach programs provide culturally acceptable, accessible, affordable, accountable, and available health services to an underserved urban off-reservation population.

The 34 programs engage in a variety of activities, ranging from the provision of outreach and referral services to the delivery of comprehensive ambulatory health care. Services currently include medical services, dental services, community services, alcohol and drug abuse prevention, education and treatment, AIDS and sexually transmitted disease education and prevention services, mental health services, nutrition education and counseling services, pharmacy services, health education, optometry services, social services, and home health care. Fourteen of the programs are designated as Federally Qualified Health Centers (FQHC) and provide services to Indians and non-Indians.

Ambulatory medical care services are provided throughout the off-reservation Indian health programs, including: pre-and postnatal care; women's health; immunizations for both children and adults; pediatrics; chronic disease (geriatric health and diabetes) clinics; adult health; maintenance; acute medical care, infectious disease treatment and control (tuberculosis, sexually transmitted disease); and referral to specialized providers when needed. Dental care services are provided by many programs, including preventive and restorative direct patient care. Dental education and screening for both children and adults are provided in both the clinic and community settings. When needed, referrals are made to specialists for orthodontics, periodontics, selected restorative procedures, and oral surgery.

Community outreach services are provided throughout the urban (off-reservation) health programs, including: patient and community education; patient advocacy; outreach and referral; and transportation. The outreach worker serves an important function as a liaison between the off-reservation health program and the community, and works to make health services more available and accessible to those community members who need them.

Alcohol and substance abuse prevention, education, treatment, and rehabilitation services are provided through program and community based services. Included as prevention and education programs are as follows: community education conferences, seminars, and workshops targeting

adolescents; identification of high-risk clients in the clinic and community; and appropriate referral for those at risk. Included in the treatment and rehabilitation programs are assessments for alcohol and drug abuse, appropriate intervention, outpatient and treatment programs, and aftercare and follow-up services.

Alcohol treatment services are provided at 10 off-reservation Indian sites originally funded by the National Institute of Alcohol Abuse and Alcoholism (NIAAA). Funds were transferred into the Urban Indian Health Program in FY 1993 to continue these Urban treatment centers under Title V of the Indian Health Care Improvement Act. The NIAAA programs, established within urban sites, are in the final stages of being transferred.

The AIDS and sexually transmitted disease (STD) information is provided at conferences, seminars, workshops, and community meetings at all of the IHS Title V funded off-reservation Indian health programs. These education and prevention services include culturally sensitive information provided to a variety of audiences through the use of posters, pamphlets, presentations, and community education. Additional AIDS services include HIV testing, pre and post-test counseling, family support groups, and referral for additional treatment if needed.

Mental health and social services include individual family and group counseling and support groups to address the problems of abuse, self-esteem, depression, and other emotional problems and conditions.

Additional services available at various off-reservation Indian health programs include, primary and secondary prevention activities, i.e., diabetes, maternal and child health, women's health, men's health, nutrition education, counseling for prenatal care, chronic health conditions, social services, community health nursing, home health care, and other health promotion and disease prevention activities.

Funding for the Urban Indian Health Program during the last five years has been as follows:

Year	Funding	FTE
1998	25,288,000	5
1999	26,382,000	4
2000	27,813,000	5
2001	29,843,000	5
2002	30,947,000	5

ACCOMPLISHMENT

Some of the accomplishments of the urban Indian health program (UIHP) include: continued substantial programmatic involvement with the national urban Indian health organization through a cooperative agreement, continued participation in the IHS budget formulation process, participation in the reauthorization of the Indian Health Care Improvement Act (P.L. 94-437), facilitation of urban Indian health program board of director training, and planning for urban information technology and data collection.

The national urban Indian organization is the National Council of Urban Indian Health (NCUIH). The Council focuses on its' policy concerns and communications among the nation's urban Indian health programs.

The urban Indian health program was involved in and participated in the FY 2002 and FY 2003 budget formulation processes. The purpose is to formulate a budget that reflects the priorities of the Indian Health Service, Tribal health programs and urban Indian health programs.

The urban Indian health program provided board of director training to urban Indian health programs throughout the nation. The training addresses the roles and responsibilities of a board of directors, as well as its relationship to its executive directors.

PERFORMANCE PLAN

The following performance indicators are included in the IHS FY 2003 Annual Performance Plan. These indicators are sentinel indicators representative of some of the more significant health problems affecting AI/AN. At this funding level, IHS would be able to achieve the following:

Indicator 18: During FY 2003, increase by two sites the number of Urban Indian health care programs that have implemented mutually compatible automated information systems which capture health status and patient care data over the FY 2002 level.

RATIONALE FOR BUDGET REQUEST

TOTAL REQUEST -- The request of $31,620,000 (including accrued costs of $92,000) is an increase of $583,000 over the FY 2002 enacted level of $30,947,000 plus accrued cost of $90,000 and 5 FTE. The increase includes the following:

Pay Cost Increases: +$583,000

The $583,000 funding received will partially cover pay costs of headquarters' staff and urban Indian health programs' staff and built-in increases associated with on-going activities.

The IHS continues to strive to increase access for the IHS patient population. Maintaining the current I/T/U health system is necessary in eliminating disparities in health status between AI/AN and the rest of the U.S. population.

Accrued Retirement and Health Benefits Costs

The increase of $2,000 is associated with the proposed Managerial Flexibility Act of 2001; the full FY 2003 accrued cost for Urban Health is $92,000. This legislation requires agencies to pay the full Government share of the accruing cost of retirement for current CSRS, CIA and Foreign Service employees, and the Coast Guard, Public Health Service and NOAA Commissioned Corps. The legislation also requires agencies to pay full accruing cost of post-retirement health benefits for current civilian employees.

ACTIVITY/MECHANISM BUDGET SUMMARY
Department of Health and Human Services
Indian Health Services - 75-0390-0-1-551
INDIAN HEALTH PROFESSIONS

Program Authorization:

Public Law (P.L.) 94-437, the Indian Health Care Improvement Act (IHCIA), as amended, authorizes program, Title I, Indian Health Manpower.

	2001 Actual	2002 Appropriation	2003 Estimate	Increase Or Decrease
Current Law BA	$30,486,000	$31,165,000	$35,373,000	+$4,208,000
Accrued Cost 1/	101,000	108,000	110,000	+2,000
Proposed Law BA	$30,587,000	$31,273,000	$35,483,000	+$4,210,000
FTE	18	18	18	-0-

1/ Please see Exhibit S for the crosswalk from current law to proposed law to reflect the Administration's proposal for full accrued retirement and health benefits.

PURPOSE AND METHOD OF OPERATION

The Indian Health Care Improvement Act (IHCIA), Public Law (P.L.) 94-437, as amended, cites as national policy the elevation of the health status of American Indians and Alaska Natives (AI/AN) to the highest possible level. Critical elements of this policy are Title I, Indian Health Professions, and Title II, Health Services. These titles support three interdependent objectives: (1) enable AI/AN to enter the health care professions through a carefully designed system of preparatory, professional, and continuing educational assistance programs; (2) serve as a catalyst to the development of Indian communities by providing educational opportunities and enabling AI/AN health care professionals to further Indian self-determination in the delivery of health care; and (3) help to ensure the continued staffing of Indian health programs with well qualified health care providers.

The IHS has implemented sections 102, 103, 104, 105, 108, 110, 112, 114, 120, and 217 of the IHCIA as funds have been appropriated. These sections of Title I, coupled with Section 217 (Title II), of the IHCIA provide authorization to support a scholarship program, a loan repayment program, temporary employment of students during nonacademic periods, tribal recruitment and retention and matching scholarship programs, health professions recruitment programs, and programs to develop and maintain American Indian psychology career recruitment programs as a means of encouraging Indians to enter the mental health field.

Scholarships help to create health professionals

The scholarship and loan repayment programs each play a role in the recruitment and retention of health professionals but from different perspectives. Scholarships are recruitment tools in three ways:

1. They affect the "creation" of a health professional by

   a. Supporting recipients as they prepare for entry into a health professional school, through section 103; and

b. While they are actually pursuing a health professional education (section 104).

2. They enable students who could never have afforded to finance an advanced education on their own to become health professionals; and

3. They require section 104 recipients to incur a service obligation. This obligation must be satisfied by providing services in an Indian health program in the profession for which the person was trained.

Scholarships become retention tools after the recipient has served their obligation because the person has been exposed to life in Indian health and is likely to decide to remain. In many instances, scholarship recipients serve their obligations in facilities on or near their home reservations and are inclined to remain there.

Loan Repayment attracts already-trained professionals.

The loan repayment program works from the other end of the educational continuum. When a person applies for loan repayment, they have completed, or nearly completed, their training and are ready to begin working in their chosen profession. Most health professionals have incurred substantial debt loads over the time of their education (The average debt load of the 272 people entering the loan repayment program in FY 2000 was $64,000.), so the opportunity to pay them off while working in their chosen profession is very attractive. Because it is possible to renew their contracts until their loans are paid off, the program is also an excellent retention tool.

These programs, as well as other recruitment and retention incentives, are necessary because Indian health programs are experiencing critical shortages of physicians, nurses, dentists, pharmacists, and optometrists and a growing concern in other professions essential to staffing Indian health programs, e.g., laboratorians, medical imaging personnel, mid-level providers, mental health professionals, etc. The Indian Health Professions recruitment and retention activities authorized in sections 102 and 110 are essential to enabling Indian health programs to effectively staff and manage their comprehensive health care delivery system. Competition for health care professionals will continue to increase in FY 2002, with vacancy rates and turnover rates also expected to increase. This will place an ever-greater burden on the IHS Indian Health Professions recruitment and retention programs.

In FY 2001, the IHS made 26 grants to tribes, Indian organizations, and academic institutions to assist in the recruitment, retention, and education of health professionals

Section 102 authorizes grants to public or nonprofit private health or educational entities, Indian tribes, or tribal organizations to identify AI/AN interested in the health professions and recruit them into the health professions. The grantees provide nurturing and cultural support for AI/AN students as they move from reservation settings to the world of academia. In FY 2001, awards were made to the Lac Courte Oreilles Tribe, the Chippewa Cree Tribe, and the Northwest Portland Area Indian Health Board. These grants are for a project period ending July 31, 2002.

During FY 2001, the programs funded under the authority of Section 102 provided career information and counseling to more than 1,500 AI/AN students. These programs also

provided scholarship and career information to more than 80 percent of their new applicants for other programs in public health as well as expanding their recruitment roles to include all health professions. The students recruited by these consortia and tribes are AI/AN individuals who have expressed interest in returning to their Indian communities to practice their health profession.

Section 103 authorizes two scholarship programs, the Health Professions Preparatory Compensatory Preprofessional Scholarship and the Health Professions Preparatory Pregraduate Scholarship. The Health Professions Preparatory Compensatory Preprofessional Scholarship provides funding to AI/AN students for up to 2 years for preprofessional education leading to enrollment in a health professions curriculum and support for compensatory education required for acceptance into a health professions curriculum. In FY 2001, 33 new scholarships were awarded in this section, with 26 continuations.

The Health Professions Preparatory Pregraduate scholarship program authorized under Section 103 provides funding for up to 4 years to AI/AN students who are in premedicine or predentistry. For FY 2001 there were 29 new awards in this section and 56 continuations.

Section 104 authorizes scholarships to AI/AN students who are enrolled or accepted for matriculation in the health professions leading to graduation and service in the IHS and other Indian Health Programs. Upon graduation in the health professions curriculum, these students are obligated to serve for from two to four years, providing professional services to AI/AN people by working in the IHS, tribal health programs funded under P.L. 93-638 (the Indian Self Determination Act), Urban programs funded under Title V of P.L. 94-437, or in private practice in a health professions shortage area serving a substantial number of Indians as determined by the Secretary, DHHS. FY 2001 saw 80 new awards and 263 continuations in this section.

Section 105 authorizes the IHS Extern Program. This program provides Health Professions Scholarship recipients and other health and allied health profession students the opportunity to gain practical experience during non-academic periods of the school year by working in the IHS. The Extern Program provides for one round trip to the work site from school and provides the funding for an individual's salary while they are in the externship. All Section 104 scholarship recipients are entitled to an externship during any non-academic period of the year. Other students are eligible to participate in the Extern program during any non-academic period provided funds are available after the Health Professions students are funded. As many as 240 externs have participated in the program in any given fiscal year.

Section 108 authorizes the repayment of loans incurred by health professionals during their education in exchange for a minimum service obligation of 2 years in the IHS, tribal programs funded under P.L. 93-638, Buy Indian contractors funded pursuant to 25 U.S.C. 47, or Title V (P.L. 94-437) urban Indian programs. In FY 2001, 386 contracts were awarded to participants in the IHS Loan Repayment Program. Of those, 76 were renewals.

Section 110 authorizes the IHS to fund competitively Indian tribes and tribal and Indian organizations to recruit, place, and retain health professionals to meet the staffing needs of Indian health programs: IHS, tribal programs funded under P.L. 93-638 or Buy Indian contractors funded

pursuant to 25 U.S.C. 47, or Title V (P.L. 94-437) urban Indian programs. In FY 1999, Section 110 grants were made to the Northwest Portland Area Indian Health Board, the Dallas Inter-Tribal Center, the Fallon Paiute-Shoshone Tribe, the Greenville Rancheria Tribal Health Program, the Houlton Band of Maliseet Indians, the Nisqually Indian Tribe, and the Tanana Chiefs Conference, Inc. The project period for these grants ends July 31, 2002.

Section 112 authorizes the IHS to provide competitive grants to:

1. Public or private schools of nursing, tribally controlled community colleges, and tribally controlled post secondary vocational institutions (as defined in Section 390(2) of the Tribally Controlled Vocational Institutions Support Act of 1990 (20 U.S.C. 2397(h)(2)); and

2. Nurse midwife and nurse practitioner programs provided by any public or private institutions.

In FY 1999, awards were made to the Arizona State University, the Salish Kootenai College, the University of North Dakota at Grand Forks, and the University of Wisconsin at Eau Claire, the University of Oklahoma, the Sisseton-Wahpeton College, and the University of South Florida. These grants will be re-competed in July 2003.

Section 114 authorizes the IHS to provide competitive grants to colleges and universities for the purpose of maintaining and expanding Native American health careers programs known as the Indians into Medicine Program (INMED). In FY 2001 they funded INMED programs at the University of North Dakota at Grand Forks and the University of Arizona (UA). The grants will expire in FY 2004 and due to the University of North Dakota's program being authorized in the legislation, only the UA will be re-competed.

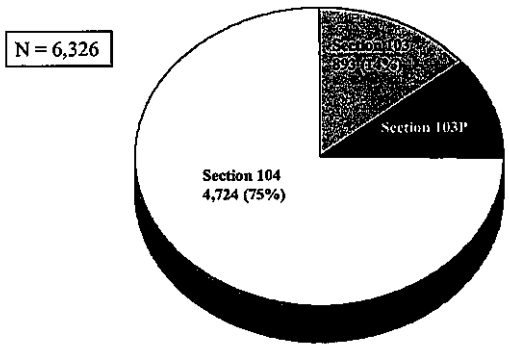
Section 120 authorizes the use of up to 5 percent of funds from Section 104 for competitive grants to tribes and tribal organizations to assist them in educating Indians to serve as health professionals in Indian communities. In FY 1999, Section 120 grants were made to the Chippewa Cree Tribe, the Ketchikan Indian Corporation, the Shingle Springs Rancheria, the Southcentral Foundation, and the Eastern Band of Cherokee. These grants will be re-competed in FY 2002.

Section 217 authorizes the IHS to provide competitive grants to colleges and universities for the purpose of developing and maintaining American Indian psychology career recruitment programs as a means of encouraging AI/AN to enter the mental health field. In FY 2001, the University of North Dakota American Indians into Psychology Program was named in the authority and awarded a grant. Additional funds were appropriated in the amount of $700,000 for FY 1999. Of this amount, the Congress earmarked $250,000 each for the Universities of Montana and North Dakota and through the competitive grant process Oklahoma State University was also awarded a grant. The project period for these grants ends September 15, 2004.

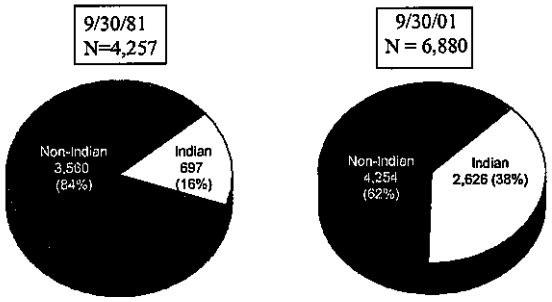
ACCOMPLISHMENTS

The following graphs illustrate the accomplishments of the scholarship and loan repayment programs over their years of existence.

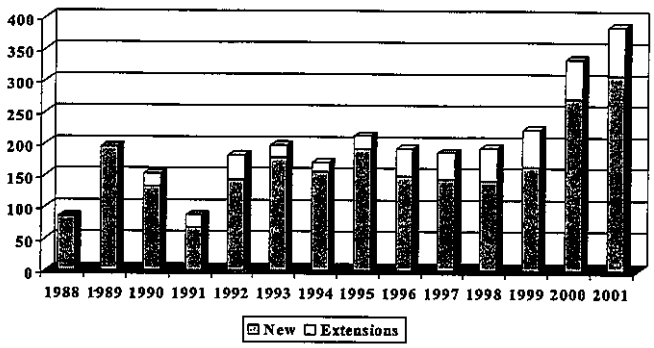
INDIAN HEALTH SERVICE
SCHOLARSHIP AWARDS
FY 1975 - FY 2001
BY P.L. 94-437 SECTION



INDIAN HEALTH SERVICE
HEALTH PROFESSIONAL STAFF
9/30/81 vs 9/30/01



Indian Health Service Loan Repayment Program
Awards by Fiscal Year
Fiscal Years 1988-2001



As the graphs show, over the period of its existence, the IHS Scholarship Program has made more than 6,600 awards, 76 percent of which were to students in their professional studies (Section 104). From 9/30/81 to 9/30/2001, total IHS professional staff grew by 62 percent while Indian professional staff grew by 277 percent. The proportion of professional staff that is Indian increased by 137 percent over that same period. It is certain that the vast majority of these Indian professionals were scholarship recipients.

The Loan Repayment Program's (LRP) contribution to IHS staffing has been as both recruitment and a retention tool. Professionals are attracted to the IHS because of the LRP, stay beyond the required two-year period in order to have a larger proportion of their loans repaid, as evidenced by the increasing number of extensions over the years, and remain in Indian health programs after their obligations are completed.

It is important to note that the data presented above do not include scholarship recipients who are employed outside the IHS. This information is not available to us at this time. If this information were available, the numbers of Indian professionals working in Indian health programs would surely be much larger.

Following are the funding levels for the last 5 fiscal years:

Year	Funding	FTE
1998	$28,720,000	16
1999	$29,623,000	16
2000	$30,491,000	20
2001	$30,486,000	18
2002	$31,165,000	18

RATIONALE FOR BUDGET REQUEST

TOTAL REQUEST -- The request of $35,483,000 (including accrued costs of $110,000) and 18 FTE is an increase of $4,210,000 over the FY 2002 enacted level of $31,165,000 plus accrued cost of $108,000 and 18 FTE. The increases are as follows:

Pay Cost Increases - +$60,000

The request of $60,000 for federal personnel-related costs funds the increased cost of providing health services to IHS beneficiaries and other increases associated with on-going operations. Included are increases such as the FY 2002 pay raise, within grade increases, increased cost of patient travel, increased cost of rents, communications, and utilities, increased cost of providing health care through the contracts and grants mechanism, increased cost of equipment, etc.

Recruit Former Military Health Professionals: +$4,150,000

Health professionals trained by the military are a potential recruitment source for the Indian Health Service health programs, including those programs that are tribally operated. Funds would be used to establish collaborative relations with the Department of Defense and the Veterans Administration (e.g., holding job fairs at military medical institutions that are being closed) and for such things as recruitment activities (e.g., newspaper ads, direct mailings, travel) and covering the relocation expenses of persons hired by Indian Health Service programs. These funds would also be used to provide scholarships and loan repayments to former military health professionals on the same basis as scholarships and loan repayments are currently provided to other individuals, recruitment bonuses at the time of initial appointment, and supplemental funds for temporary staff support.

Accrued Retirement and Health Benefits Costs

The increase of $2,000 is associated with the proposed Managerial Flexibility Act of 2001; **the full accrued cost in FY 2003 for Indian Health Profession is $110,000.** This legislation requires agencies, beginning in FY 2003, to pay the full Government share of the accruing cost of retirement for current CSRS, CIA and Foreign Service employees, and the Coast Guard, Public Health Service and NOAA Commissioned Corps. The legislation also requires agencies to the pay full accruing cost of post-retirement health benefits for current civilian employees. The intention of the legislation is to budget and present the full costs of Federal employees in the accounts and programs where they are employed. This legislation is part of an initiative to link budget and management decisions to performance by showing the full cost of each year's program operations together with the output produced that year. These accrual costs are shown comparably in FY 2001 and FY 2002.

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ACTIVITY/MECHANISM BUDGET SUMMARY
Department of Health and Human Services
Indian Health Services - 75-0390-0-1-551
TRIBAL MANAGEMENT

Program Authorization:

Program authorized by Indian Self Determination and Education Assistance Act, P.L. 93-638, as amended, Sections 103(b)(2) and 103(e) P.L. 100-472, P.L. 100-472 and P.L. 103-413.

	2001 Actual	2002 Appropriation	2003 Estimate	Increase or Decrease
Current Law BA	$2,406,000	$2,406,000	$2,406,000	$0
Accrued Costs 1/	0	0	0	0
Proposed Law BA	$2,406,000	$2,406,000	$2,406,000	$0

1/ Please see Exhibit S for the crosswalk from current law to proposed law to reflect the Administration's proposal for full accrued retirement and health benefits.

PURPOSE AND METHOD OF OPERATION

The Public Law 93-638, the Indian Self-Determination Act of 1976, authorized funding to develop the capacity of tribes to manage health care programs. In October 1988, Congress passed P.L. 100-472, the Indian Self-Determination Act Amendments to facilitate and simplify the process by which tribes and tribal organizations may assume management responsibility of IHS programs. In October 1994, Congress passed P.L. 103-413, the Indian Self-Determination Act Amendments, reaffirming maximum participation of Indian Tribes in programs, services, functions, and activities conducted by the Federal Government for Indians. The Amendments provide for a non-contracting "model agreement" to encourage and support the right of Indian Tribes to control and operate their own health programs.

Since FY 1988, these funds have been distributed through the Tribal Management Program for American Indians and Alaska Natives. This national grant program competitively awards tribal management funds to tribes and tribal organizations for various capacity building activities such as strategic planning and improving tribal health management structures. These activities have provided tribes and tribal organizations with effective health strategies for managing their programs and staff.

ACCOMPLISHMENT

Over the last 25 years, tribal operations of health programs have steadily increased. For example, 53 percent of the FY 2000 IHS service budget was utilized to fund tribal programs. The Tribal Management Grant Program began in 1988 by providing 50 grants to tribes and tribal organizations to build their management capabilities in preparation for assumption of IHS programs. Since then over 250 tribes and 60 Alaska Native Villages have participated in the program to improve their management capacity. In FY

2001, 23 new grants and 6 continuation grants were awarded to tribes and tribal organizations.

Following are the funding levels for the last 5 fiscal years:

Year	Funding	
1998	$2,348,000	
1999	$2,390,000	
2000	$2,411,000	
2001	$2,406,000	
2002	$2,406,000	President's Budget

RATIONALE FOR BUDGET REQUEST

TOTAL REQUEST - The request of $2,406,000 for this competitive grant activity will enable IHS to continue assisting tribes to build their tribal management activity.

ACTIVITY/MECHANISM BUDGET SUMMARY
Department of Health and Human Services
Indian Health Services - 75-0390-0-1-551
DIRECT OPERATION

Program Authorization:

Program authorized by U.S.C. 13, Snyder Act, and P.L. 83-568, Transfer Acts, 42 U.S.C. 2001.

	2001 Actual	2002 Appropriation	2003 Estimate	Increase Or Decrease
Current Law BA 2/	$52,196,000	$54,524,000	$54,474,000	-50,000
Accrued Costs 1/	8,323,000	8,875,000	9,084,000	+209,000
Proposed Law BA	$60,519,000	$63,399,000	$63,558,000	+159,000
FTE 3/	1,483	1,483	1,433	-50

1/ Please see Exhibit S for the crosswalk from current law to proposed law to reflect the Administration's proposal for full accrual retirement and health benefits.

2/ Excludes $750,000 in FY 2001 and $799,000 in FY 2002 for proposed transfer of Legislative and Public Affairs to the Office of the Secretary.

3/ Of these totals, approximately 954 are charged and reimbursed to Direct Operation for Areas' MOA/IPA Self Governance compacts.

PURPOSE AND METHOD OF OPERATION

Executive direction, program management and administrative support constitute critical elements in the delivery of health care to American Indians and Alaska Natives (AI/AN). **No unit of health service is delivered without substantial program management and administrative support from different disciplines,** i.e., health assessment, policy development, finance, procurement, program evaluation, supply management, personnel, equipment, training, etc.

The many unusual circumstances relating to the direct delivery of health services to AI/AN require the adoption of special management principles and accompanying organizational structure. The IHS has substantially increased its tribal consultation activities in recent years. As more tribes contract or compact to manage their own health programs, IHS has provided more technical assistance to tribes. This requires an additional dimension of administrative and program management expertise not ordinarily encountered in other Federal programs. An understanding of the way that the IHS provides, directly and indirectly through Tribal and Urban Indian health programs, a vast array of services to the diverse and dispersed AI/AN populations is important in order to appreciate the management, oversight, and tribal consultation and their direct influence on budget formulation and execution activities.

In response to these functions, the IHS has structured its organization, delegated the necessary authorities and assigned the appropriate management responsibilities in three principal levels: (1) national (Headquarters); (2) regional (Area Office); and (3) local (Service Unit or facility). This

structure allows effective programmatic oversight, local management, and tribal consultation at any level, while capitalizing on the economies of scale made possible by collaborative or aggregate activities. The requirements of each level are unique, interrelated, and complementary to assure an uninterrupted execution of program and administrative management. To the greatest extent practicable and feasible, the delegation of authorities at the community level has and will enable timely decisions in patient care.

Headquarters

The Headquarters provides essential integration at the national level, assuring consistency of policy and practice across the many diverse locations served by IHS. For example, without this integration, it would be impossible to address the issue of equity and ensure the integrity at a national comprehensive healthcare delivery system. Headquarters carries out national functions, including the responsibilities of a Federal Agency such as establishment, implementation, and oversight of program and administrative policy, strategic and operational planning, budget formulation and execution, administrative control of funds, Federal Managers Financial Integrity Act (FMFIA), Government Performance and Results Act (GPRA), procurement, facilities construction planning, and many related functions in compliance with applicable laws and regulations.

Headquarters staff, through two principal offices of management support and public health, advise and support the Director on programmatic and administrative issues, and respond to the many and diverse requests that come to the Agency from the Department, OMB, the Congress, and other Federal Agencies. Headquarters personnel also monitor, coordinate, and evaluate Area and local activities and programs to ensure conformance with congressional and other directives. They manage certain Nation-wide support functions such as the catastrophic health emergency fund, health facilities construction, and grant programs that make awards to tribes, urban Indian health programs, Indian organizations, and individuals, for purposes such as diabetes prevention and treatment, the development or enhancement of management infrastructure to permit tribes to manage health programs, the education of health professionals who will work in Indian communities, and the retention of health professionals by assisting with the repayment of student loans. Additionally, Headquarters personnel provide information and reports to the Congress and the Executive Branch, technical assistance to tribes and Areas, and act in an advocacy and leadership role with other Federal agencies, professional associations, and other entities that may contribute to fulfilling the IHS mission.

Area Offices

Area Offices are responsible for carrying out a dual function: (1) to participate in and establish goals and objectives implementing IHS policies, and determine priorities for action within the framework of IHS policy. As such, Area Offices coordinate their respective activities and resources internally and externally with those of other governmental and non-governmental programs to promote optimum utilization of all available health resources. The burden of negotiating, consulting, and participating with the approximately 550 sovereign Indian nations rests primarily with the Area Offices which must work in partnership with the Indian nations while remaining agents of the Federal government. And, **(2) ensure the delivery of quality health care through their respective service units and participate in the development and**

demonstration of alternative means and techniques of health services management and delivery to provide Indian tribes and other Indian community groups with optimal ways of participating in Indian health programs. As an integral part of this dual function, the Area Offices are principally responsible for assuring the development of individual and tribal capabilities to participate in the operation of the IHS program as deemed appropriate by the tribes.

ACCOMPLISHMENT

Self-Governance Authority

In FY 1993 and 1994, the Indian Health Service implemented a demonstration program in Tribal Self-Governance and negotiated with tribes the first 14 compacts and annual funding agreements. After the necessary policies and decisions regarding financial allocation were developed and implemented, Congress made Tribal Self-Governance Authority permanent in FY 2000. **In FY 2002, we anticipate that $777 million will be transferred to support 78 compacts with tribes.**

Organizational Change

Significant changes have occurred in the Indian Health Service in recent years. Changes were necessary to ensure a structure and staffing sufficient to carry out inherent Federal functions while maximizing efficiency in management and administration to permit the shift of resources to the point of health service delivery, including federal service units and tribal health programs.

The reorganization of the IHS Headquarters in 1997 accomplished the following. First, the changes to the IHS Headquarters structure emphasizes the focus of functions on leadership and advocacy for American Indian and Alaska Native health programs and initiatives, and provides support to IHS direct, Tribal, and urban Indian health programs. An analysis of functions and activities occurred and those functions and activities directly in support of the Director, IHS, and the core Headquarters functions were retained at IHS Headquarters in Rockville, Maryland. Other functions and activities that did not meet the criteria of core functions were transferred, redefined, or eliminated.

Specific changes include decreasing the number of Headquarters organizational components from 111 within 10 major Offices, to 38 organizational components within 3 major Offices. This required the transfer and/or merging of functions between organizations and the transfer of personnel between organizations. The reduction in the total number of organizational components significantly de-layered the organization, providing greater decision making at lower management levels.

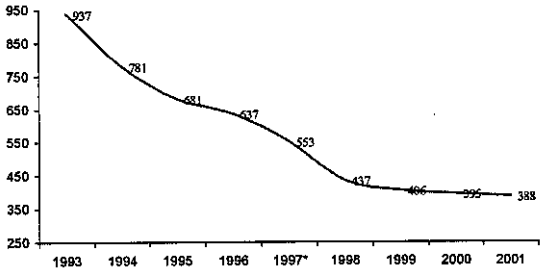
In addition, two Headquarters components were transferred to Area Office administration. First, the Program Planning component of the former Office of Health Program Research and Development was transferred to the newly established Tucson Area Office. Second, the Clinical Support Center was previously a Headquarters branch whose functions included training programs for mid-level providers. Pursuant to the 1997 reorganization, the Clinical Support Center personnel and functions were transferred to

the Phoenix Area Office. These transfers are consistent with the increased delegations from Headquarters to Area level operations.

In October 2000, the Headquarters Office of Public Health accomplished further restructuring by reducing by 30 positions, the total number of authorized positions in Office of Public Health. Functions were analyzed and reorganized to better respond to specific and current health issues.

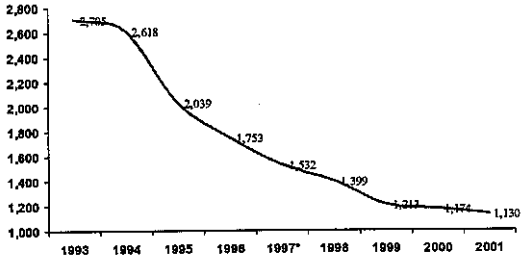
An IHS workforce report indicates that at the end of FY 2001, the Indian Health Service had 14,668 FTE on board and of this number, 954 are assigned to tribes through Inter-Governmental Act Assignments or Memoranda of Agreement. Such agreements are important to achieving self-determination, as they minimize recruitment problems at the time of the transfer of programs to the tribes. Continued Federal support through Direct Operations includes such costs as payroll processing and workman's compensation for FTE assigned to tribes.

IHS Headquarters Workforce: 1993 – 2001
FTE Declined by 549 (-59%)



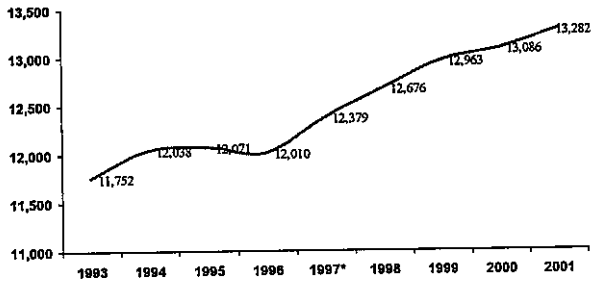
* Began implementation of IHS organizational redesign

IHS Area Office Workforce:1993 – 2001
FTE Declined by 1,573 (-58%)



* Began implementation of IHS organizational redesign

Service Units Workforce: 1993 – 2001
FTE Increased by 1,530 (+13%)



* Began implementation of IHS organizational redesign

IHS Business Plan

Concurrent with organizational changes, the Indian Health Service shifted to a corporate-oriented approach to conducting business. The Indian Health Service developed, together with Indian leaders, a business plan to adopt more business-like planning and practices in key segments of Indian Health Service operations. The plan set a course for management that has resulted in important accomplishments and enhanced stewardship of important resources.

First, **the Indian Health Service launched a hospital cost report initiative that has helped Indian Health Service more accurately identify its hospital cost and set higher reimbursement rates for patients with Medicare, Medicaid, and or private insurance coverage.** In addition, the Indian Health Service has improved its systems to identify third party eligibility, document services provided, and automate third party billing and tracking. These business initiatives have been instrumental in helping the Indian Health Service to increase third-party collections by almost $188 million, or 67 percent, between FY 1996 and FY 2001. In addition, Area Offices have negotiated with contract-providers, Medicare-like rates to make Contract Health Service dollars go farther, refinements to the Contract Support Cost Policy have reduced the potential for paying duplicate costs, and current efforts to link billing with accounts receivable hold the promise of strengthening internal management and operations.

Performance Measures

The Direct Operations budget contributes to the achievement of the following performance indicators that are included in the IHS FY 2003 Annual Performance Plan. These indicators address some of the administrative aspects of providing health care to AI/AN population.

Indicator 37: During FY 2003, the IHS will improve stakeholder satisfaction with the IHS consultation process by 5 percent over the FY 2002 baseline.

Indicator 38: During the FY 2003 reporting period, the IHS will have improved the level of Contract Health Services (CHS) procurement of inpatient and outpatient hospital services for routinely used providers to at least 1 percent over the FY 2002 level of the total dollars paid to contract providers or rate quote agreements at the IHS-wide reporting level.

Indicator 39: By the end of FY 2003, the IHS will have completed a systematic assessment of the public health infrastructure for Headquarters and six of the Area Offices.

Indicator 40: During FY 2003, the IHS will continue to expand Managerial Cost Accounting (MCA) capacity through an incremental investment in necessary information technology in accord with DHHS and OMB guidance.

Indicator 41: By the end of FY 2003, the IHS will increase by 10 percent over the FY 2002 level the proportion of I/T/U's who have implemented Hospital and Clinic Compliance Plans to assure that claims meet the rules, regulations, and medical necessity guidance for Medicare and Medicaid payment.

Indicator 42: During FY 2003, the IHS will support the efficient, effective and equitable transfer of management of health programs to tribes submitting proposals or letters of intent to contract or compact IHS programs under the Indian Self-Determination Act by:

a. providing technical assistance to all tribes (100 percent) submitting proposals or letters of intent based on identified areas of need and with specific technical assistance in the area of calculating contract support costs.
b. reviewing all initial contract support cost requests submitted (100 percent) using a IHS Contract Support Cost Policy Review Protocol to assure the application of consistent standards in order to assure equitable and approvable requests.

Indicator 43: For FY 2003, the IHS will improve its overall Human Resource Management (HRM) Index score to at least one point above the FY 2002 level as measured by the DHHS annual HRM survey.

Indicator 44: During FY 2003, the IHS will systematically work to improve nurse retention rates by:

- Implementing the National Council of Nurses Recruitment and Retention Plan in all IHS Areas and Headquarters.
- Assessing vacancy, turnover and retention rates using the position reports to identify those locations where nursing vacancy and retention rates are most problematic.

Following are the funding levels for the last 5 fiscal years:

Year	Funding	FTE
1998	$47,386,000	465
1999	$49,309,000	434
2000	$50,988,000	1,629
2001	$52,946,000	1,483
2002	$55,323,000	1,433

RATIONALE FOR BUDGET REQUEST

TOTAL REQUEST -- The request of $63,558,000 (including accrued costs of $9,084,000) is a net increase of $159,000 and a decrease of 50 FTE over the FY 2002 enacted level of $55,323,000 minus $799,000 (Legislative & Public Affairs Transfer) and plus $8,875,000 of accrued costs and 1,483 FTE. The increases/decreases are as follows:

Pay Cost Increase: +$2,095,000

The request of $2,095,000 for federal/tribal/urban (I/T/U) pay costs would fund the increases associated with on-going operations.

The IHS continues to strive to increase access for the IHS patient population. Maintaining the current I/T/U health system is necessary in eliminating disparities in health status between American Indians and Alaska Natives and the rest of the U.S. population.

Information Technology: +$2,500,000

The program increase will provide developmental level funding to partially meet the IHS contribution to the HHS Information Technology Strategic Five Year Plan to strengthen critical IT infrastructure. (See Information Technology budget narrative for complete justification.)

The IHS' request includes funding to support Departmental efforts to improve the HHS Information Technology Enterprise Infrastructure. The request includes funds to support an enterprise approach to investing in key information technology infrastructure such as security and network modernization. These investments will enable HHS programs to carry-out their missions more securely and at a lower cost. Agency funds will be combined with resources in the Information Technology Security and Innovation Fund to promote collaboration in planning and project management and to achieve common goals such as secure and reliable communication and lower costs for the purchase and maintenance of hardware and software.

Administrative & Management Reform: -$4,436,000 and -50 FTE

The IHS will save $4,436,000 through management improvements which will result in a saving of 50 FTE and $2,950,000. In addition, we will judiciously control and reduce costs associated with administrative travel, overtime, copying, and the purchase of administrative equipment and supplies. In addition we will place a moratorium on the acquisition of additional administrative office space and carefully control training costs, promoting distance learning and training at the local level whenever applicable.

Accrued Retirement and Health Benefits Costs

The increase of $209,000 between FY 2001 and FY 2002 is associated with the proposed Managerial Flexibility Act of 2001; **the full accrued cost in FY 2003 for Direct Operations is $9,084,000.** This legislation requires agencies, beginning in FY 2003, to pay the full Government share of the accruing cost of retirement for current CSRS, CIA and Foreign Service employees, and the Coast Guard, Public Health Service and NOAA Commissioned Corps. The legislation also requires agencies to the pay full accruing cost of post-retirement health benefits for current civilian employees. The intention of the legislation is to budget and present the full costs of Federal employees in the accounts and programs where they are employed. This legislation is part of an initiative to link budget and management decisions to performance by showing the full cost of each year's program operations together with the output produced that year. These accrual costs are shown comparably in FY 2001 and FY 2002.

Unified Financial Management System

The Unified Financial Management System (UFMS) will be implemented to replace five legacy accounting systems currently used across the Operating Divisions. The UFMS will integrate the Department's financial management structure and provide HHS leaders with a more timely and coordinated view of critical financial management information, including more accurate assessments of the cost of HHS programs. It will also promote the consolidation of accounting operations and thereby reduce substantially the cost of providing accounting services throughout HHS. Similarly, UFMS, by generating timely, reliable and consistent financial information, will enable OPDIV Heads and program administrators to make more timely and informed decisions regarding their operations.

Transfer of Legislative and Public Affairs to the Office of the Secretary

The budget request includes the transfer of the IHS' Legislative and Public Affairs offices to the Office of the Secretary where all legislative and public affairs functions in the Department will be consolidated into two offices by the end of FY 2003. The transfer includes $838,000 and 8 FTE.

ACTIVITY/MECHANISM BUDGET SUMMARY
Department of Health and Human Services
Indian Health Services - 75-0390-0-1-551
SELF GOVERNANCE

Program Authorization:

Program authorized by Title V, Tribal Self-Governance, P.L. 93-638, Indian Self Determination Act, as amended.

	2001 Actual	2002 Appropriation	2003 Estimate	Increase Or Decrease
Current Law BA	$9,803,000	$9,876,000	$10,089,000	+$213,000
Accrued Cost 1/	45,000	48,000	49,000	+1,000
Proposed Law BA	$9,848,000	$9,924,00	$10,138,000	+$214,000
FTE	8	8	8	0

1/ Please see Exhibit S for the crosswalk from current law to proposed law to reflect the Administration's proposal for full accrued retirement and health benefits.

PURPOSE AND METHOD OF OPERATION

In FY 1992, IHS was instructed by Congress to initiate planning activities with tribal governments with approved Department of Interior self-governance compacts for the development of a Self-Governance Demonstration Project as authorized by P.L. 100-472. Through enactment of P.L. 102-573, the Indian Health Care Amendments of 1992, authority to fund the tribal self-governance demonstration projects (SGDP) was extended to IHS and the Office of Tribal Self-Governance was established. Through enactment of P.L. 106-260, the Tribal Self-Governance Amendments of 2000, permanent authority was given to Title V, Tribal Self-Governance. Since 1993, the IHS, in conjunction with Tribal representatives, has been engaged in a process to develop methodologies for identification of Tribal shares for all Tribes. Tribal shares are those funds historically held at the Headquarters and Area organizational levels of the IHS. In FY 2003 approximately $777 million will be transferred to support 78 compacts.

ACCOMPLISHMENT

Tribes participating in the Tribal Self-Governance Program (TSGP) report that the program has had a significant positive impact on the health and well being of their constituents. The TSGP puts the administration and management of the health programs in the hands of tribal governments and provides them the flexibility to tailor their health programs to meet the diverse and unique needs of their constituents. Significant improvements have been made in the administration of Tribal health programs and in the quality, quantity and accessibility of services provided the service population. Thus federal funds are more effectively and efficiently used in addressing the local health needs of American Indians and Alaska Natives. The TSGP also promotes improved program and fiscal accountability in that tribal governments and health administrators are held directly accountable by and to their service population. A study conducted by the National Indian Health Board confirmed the significant positive impact that Self-Governance has had on Tribal health programs and their constituents.

Fiscal Year 2002 Compacts as Funded

FY 2002 IHS Self-Governance Compacts					
	FY 2002 Compact Amounts				
Compacts by State	IHS Services	IHS Facilities	Contract Support Costs Direct	Contract Support Costs Indirect	Total
Alabama	**$2,675,000**	**$153,000**	**$116,000**	**$579,000**	**$3,523,000**
Poarch Band of Creek Indians	$2,675,000	$153,000	$116,000	$579,000	$3,523,000
Alaska	**$269,820,000**	**$14,581,000**	**$18,037,000**	**$60,779,000**	**$363,217,000**
Alaska Native Tribal Health Consortium	$69,478,000	$12,158,000	$2,789,000	$5,271,000	$89,696,000
Aleutian/Pribilof Islands Association, Inc.	$1,816,000	$19,000	$191,000	$479,000	$2,505,000
Arctic Slope Native Association	$6,103,000	$60,000	$907,000	$2,298,000	$9,368,000
Bristol Bay Area Health Corporation	$16,519,000	$286,000	$1,571,000	$5,532,000	$23,908,000
Chugachmiut	$2,933,000	$26,000	$193,000	$1,083,000	$4,235,000
Copper River Native Association	$1,513,000	$9,000	$155,000	$520,000	$2,197,000
Council of Athabascan Tribal Government	$885,000	$9,000	$29,000	$436,000	$1,359,000
Eastern Aleutian Tribes, Inc.	$1,203,000	$12,000	$49,000	$259,000	$1,523,000
Ketchikan Indian Corporation	$3,437,000	$33,000	$733,000	$1,388,000	$5,591,000
Kodiak Area Native Association	$4,680,000	$35,000	$318,000	$1,161,000	$6,194,000
Maniilaq Association	$21,005,000	$199,000	$2,003,000	$7,654,000	$30,861,000
Metlakatla Indian Community	$2,141,000	$22,000	$109,000	$544,000	$2,816,000
Mount Sanford Tribal Consortium	$590,000	$1,000	$43,000	$178,000	$812,000
Native Village of Eklutna	$127,000	$1,000	$4,000	$19,000	$151,000
Norton Sound Health Corporation	$14,890,000	$183,000	$1,350,000	$3,979,000	$20,402,000
Seldovia Village Tribe	$663,000	$2,000	$16,000	$254,000	$935,000
Southcentral Foundation	$41,272,000	$272,000	$1,868,000	$9,681,000	$53,093,000
Southeast Alaska Regional Health Corporation	$27,620,000	$238,000	$2,268,000	$5,495,000	$35,621,000
Tanana Chiefs Conference	$21,810,000	$391,000	$1,149,000	$3,698,000	$27,048,000
Yukon-Kuskokwim Health Corporation	$31,135,000	$625,000	$2,292,000	$10,850,000	$44,902,000

FY 2002 IHS Self-Governance Compacts					
	FY 2002 Compact Amounts				
Compacts by State	IHS Services	IHS Facilities	Contract Support Costs Direct	Contract Support Costs Indirect	Total
California	**$9,462,000**	**$307,000**	**$663,000**	**$3,463,000**	**$13,895,000**
Hoopa Valley Tribe	$3,309,000	$136,000	$187,000	$951,000	$4,583,000
Karuk Tribe of California	$1,803,000	$58,000	$67,000	$864,000	$2,792,000
Redding Rancheria	$4,350,000	$113,000	$409,000	$1,648,000	$6,520,000
Connecticut	**$1,046,000**	**$1,000**	**$0**	**$32,000**	**$1,079,000**
Mohegan Tribe of Indians of Connecticut	$1,046,000	$1,000	$0	$32,000	$1,079,000
Florida	**$4,098,000**	**$230,000**	**$192,000**	**$959,000**	**$5,479,000**
Seminole Tribe of Florida	$4,098,000	$230,000	$192,000	$959,000	$5,479,000
Idaho	**$9,527,000**	**$864,000**	**$827,000**	**$1,395,000**	**$12,613,000**
Coeur D'Alene Tribe	$3,544,000	$395,000	$464,000	$718,000	$5,121,000
Kootenai Tribe of Idaho	$414,000	$40,000	$55,000	$86,000	$595,000
Nez Perce Tribe	$5,569,000	$429,000	$308,000	$591,000	$6,897,000
Louisana	**$797,000**	**$75,000**	**$34,000**	**$111,000**	**$1,017,000**
Chitimacha Tribe of Louisana	$797,000	$75,000	$34,000	$111,000	$1,017,000
Maine	**$2,275,000**	**$172,000**	**$128,000**	**$536,000**	**$3,111,000**
Penobscot Indian Nation	$2,275,000	$172,000	$128,000	$536,000	$3,111,000
Massachusetts	**$483,000**	**$49,000**	**$158,000**	**$118,000**	**$808,000**
Wampanoag Tribe of Gay Head	$483,000	$49,000	$158,000	$118,000	$808,000
Michigan	**$11,279,000**	**$933,000**	**$660,000**	**$1,683,000**	**$14,555,000**
Grand Traverse Band of Ottawa and Chippewa Indians	$1,726,000	$223,000	$45,000	$509,000	$2,503,000
Keweenaw Bay Indian Community	$1,850,000	$257,000	$71,000	$288,000	$2,466,000
Sault Ste. Marie Tribe of Chippewa Indians	$7,703,000	$453,000	$544,000	$886,000	$9,586,000

FY 2002 IHS Self-Governance Compacts

Compacts by State	FY 2002 Compact Amounts				
	IHS Services	IHS Facilities	Contract Support Costs Direct	Contract Support Costs Indirect	Total
Minnesota	**$8,571,000**	**$605,000**	**$355,000**	**$1,036,000**	**$10,567,000**
Bois Forte Band of Chippewa Indians	$1,682,000	$124,000	$54,000	$312,000	$2,172,000
Fond du Lac Band of Lake Superior Chippewa	$4,993,000	$301,000	$248,000	$491,000	$6,033,000
Mille Lacs Band of Ojibwe	$1,896,000	$180,000	$53,000	$233,000	$2,362,000
Mississippi	**$10,860,000**	**$792,000**	**$937,000**	**$1,771,000**	**$14,360,000**
Mississippi Band of Choctaw Indians	$10,860,000	$792,000	$937,000	$1,771,000	$14,360,000
Montana	**$21,243,000**	**$968,000**	**$1,515,000**	**$2,569,000**	**$26,295,000**
Chippewa Cree Tribe of the Rocky Boy's Reservation	$6,909,000	$423,000	$929,000	$1,034,000	$9,295,000
Confederated Salish and Kootenai Tribes of Flathead	$14,334,000	$545,000	$586,000	$1,535,000	$17,000,000
Nevada	**$9,849,000**	**$750,000**	**$927,000**	**$2,601,000**	**$14,127,000**
Duck Valley Shoshone-Paiute Tribe	$4,852,000	$534,000	$561,000	$1,523,000	$7,470,000
Duckwater Shoshone Tribe	$747,000	$36,000	$146,000	$308,000	$1,237,000
Ely Shoshone Tribe	$845,000	$41,000	$45,000	$246,000	$1,177,000
Las Vegas Paiute Tribe	$2,046,000	$43,000	$99,000	$304,000	$2,492,000
Yerington Paiute Tribe of Nevada	$1,359,000	$96,000	$76,000	$220,000	$1,751,000
Oklahoma	**$110,844,000**	**$7,460,000**	**$6,706,000**	**$20,197,000**	**$145,207,000**
Absentee Shawnee Tribe of Oklahoma	$3,064,000	$172,000	$594,000	$487,000	$4,317,000
Cherokee Nation	$31,487,000	$1,483,000	$1,136,000	$4,390,000	$38,496,000
Chickasaw Nation	$30,318,000	$2,102,000	$1,596,000	$6,172,000	$40,188,000
Choctaw Nation of Oklahoma	$31,500,000	$3,169,000	$2,404,000	$5,247,000	$42,320,000
Citizen Potawatomi Nation	$4,457,000	$258,000	$578,000	$1,279,000	$6,572,000
Kaw Nation	$647,000	$64,000	$145,000	$200,000	$1,056,000
Kickapoo Tribe of Oklahoma	$2,693,000	$58,000	$113,000	$1,151,000	$4,015,000
Modoc Tribe of Oklahoma	$40,000	$0	$4,000	$35,000	$79,000
Ponca Tribe of Oklahoma	$2,409,000	$74,000	$15,000	$500,000	$2,998,000
Sac and Fox Nation	$3,233,000	$16,000	$94,000	$484,000	$3,827,000
Wyandotte Nation	$996,000	$64,000	$27,000	$252,000	$1,339,000

FY 2002 IHS Self-Governance Compacts					
	FY 2002 Compact Amounts				
Compacts by State	IHS Services	IHS Facilities	Contract Support Costs Direct	Contract Support Costs Indirect	Total
Oregon	**$10,137,000**	**$462,000**	**$1,394,000**	**$4,380,000**	**$16,373,000**
Coquille Indian Tribe	$1,216,000	$48,000	$171,000	$714,000	$2,149,000
Confederated Tribes of Grand Ronde	$4,462,000	$265,000	$673,000	$2,405,000	$7,805,000
Confederated Tribes of Siletz Indians of Oregon	$4,459,000	$149,000	$550,000	$1,261,000	$6,419,000
Washington	**$22,279,000**	**$1,853,000**	**$1,575,000**	**$8,593,000**	**$34,300,000**
Jamestown S'Klallam Indian Tribe	$573,000	$37,000	$68,000	$273,000	$951,000
Lower Elwha Klallam Tribe	$1,211,000	$94,000	$71,000	$299,000	$1,675,000
Lummi Indian Nation	$4,694,000	$424,000	$190,000	$1,464,000	$6,772,000
Makah Indian Tribe	$565,000	$106,000	$37,000	$130,000	$838,000
Nisqually Indian Tribe	$1,382,000	$82,000	$85,000	$501,000	$2,050,000
Port Gamble S'Klallam Tribe	$1,261,000	$149,000	$105,000	$461,000	$1,976,000
Quinault Indian Nation	$3,484,000	$437,000	$169,000	$1,875,000	$5,965,000
Shoalwater Bay Indian Tribe	$1,345,000	$39,000	$214,000	$574,000	$2,172,000
Skokomish Indian Tribe	$10,000	$0	$0	$0	$10,000
Squaxin Island Indian Tribe	$1,877,000	$183,000	$152,000	$924,000	$3,136,000
Suquamish Tribe	$1,046,000	$44,000	$114,000	$502,000	$1,706,000
Swinomish Indian Tribal Community	$1,674,000	$116,000	$136,000	$727,000	$2,653,000
Tulalip Tribes of Washington	$3,157,000	$142,000	$234,000	$863,000	$4,396,000
Wisconsin	**$6,439,000**	**$476,000**	**$224,000**	**$629,000**	**$7,768,000**
Oneida Tribe of Indians of Wisconsin	$6,439,000	$476,000	$224,000	$629,000	$7,768,000
Grand Total	$511,684,000	$30,731,000	$34,448,000	$111,431,000	$688,294,000

Following are the funding levels for the last 5 fiscal years:

Year	Funding	FTE	
1998	$9,106,000	6	
1999	$9,391,000	7	
2000	$9,531,000	7	
2001	$9,803,000	8	
2002	$9,876,000	8	President's Budget

RATIONALE FOR BUDGET REQUEST

TOTAL REQUEST -- The request of $10,138,000 (including accrued cost of $49,000) is an increase of $214,000 over the FY 2002 enacted level of $9,876,000 plus accrued cost of $48,000. The increases are as follows:

Pay Cost Increases: +$214,000

The request of $214,000 for federal/tribal/urban (I/T/U) pay costs would fund the increases associated with on-going operations.

The IHS continues to strive to increase access for the IHS patient population. Maintaining the current I/T/U health system is necessary in eliminating disparities in health status between AI/AN and the rest of the U.S. population.

Accrued Retirement and Health Benefits Costs

The increase of $1,000 is associated with the proposed Managerial Flexibility Act of 2001; **the full FY 2003 accrued cost for Health Education is $49,000.** This legislation requires agencies to pay the full Government share of the accruing cost of retirement for current CSRS, CIA and Foreign Service employees, and the Coast Guard, Public Health Service and NOAA Commissioned Corps. The legislation also requires agencies to pay full accruing cost of post-retirement health benefits for current civilian employees.

By Areas

Area	Tribal User Pop	At Large User	Program Tribal Shares	Area Tribal Shares	Headqtrs Tribal Shares	Contract Support Costs (Direct)	Contract Support Costs (Indirect)	Total
Alaska	96,385	11,865	266,297,000	10,591,000	7,513,000	18,037,000	60,779,000	363,217,000
Aberdeen	0	0	0	126,000	0	0	0	126,000
Bemidji	26,634	0	24,314,000	2,461,000	1,402,000	1,239,000	3,348,000	32,764,000
Billings	13,147	0	19,111,000	1,766,000	1,334,000	1,515,000	2,569,000	26,295,000
California	6,893	5,864	8,402,000	889,000	478,000	663,000	3,463,000	13,895,000
Nashville	14,481	0	20,325,000	2,581,000	800,000	1,565,000	4,106,000	29,377,000
Oklahoma	182,700	38,936	104,675,000	6,452,000	7,177,000	6,706,000	20,197,000	145,207,000
Phoenix	3,294	0	9,743,000	507,000	349,000	927,000	2,601,000	14,127,000
Portland	33,607	0	39,144,000	3,766,000	2,212,000	3,796,000	14,368,000	63,286,000
Total, IHS	377,141	56,665	492,011,000	29,139,000	21,265,000	34,448,000	111,431,000	688,294,000

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ACTIVITY/MECHANISM BUDGET SUMMARY
Department of Health and Human Services
Indian Health Services - 75-0390-0-1-551
CONTRACT SUPPORT COSTS

Program Authorization:

Program authorized by P. L. 93-638, Indian Self-Determination Act, as amended and P. L. 100-472, Section 106(a)(2) A & B.

	2001 Actual	2002 Appropriation	2003 Estimate	Increase Or Decrease
Current Law BA	$248,234,000	$268,234,000	$270,734,000	+$2,500,000
Accrued Cost	0	0	0	0
Proposed Law BA	$248,234,000	$268,234,000	$270,734,000	+$2,500,000

PURPOSE AND METHOD OF OPERATION

Section 106(a)(2) of P.L. 93-638, the Indian Self-Determination Act, as amended, authorizes the Secretary to fund those costs that a tribal contractor incurs in addition to what the Secretary would have otherwise provided for the direct operation of the program. These costs are referred to as contract support costs.

The IHS uses contract support cost funds made available under the ISD fund to support the initial transfer of programs from Federal operations to tribal operation. The ISD money also funds tribal requests that include Start-Up and Pre-Award costs, Direct and Indirect types of Contract Support Costs.

Amounts needed for Indirect CSC are determined in independent negotiations with the cognizant Agency's Inspector General (which is the Department of the Interior for virtually all contracts). The types of costs included in these indirect cost pools include the reasonable costs of tribal governing bodies, management and planning, financial management, property management, procurement management, data processing, office support, building rent, utilities, program specific insurance, legal services, and single-agency audits.

ACCOMPLISHMENTS

Contract support costs (CSC) is a supplement to the direct program funding provided in order to maintain an equitable opportunity for tribes who choose to operate programs under this legislative authority.

In 1997, the Congress directed the IHS to "work with Tribes, the Bureau of Indian Affairs and the Inspector General at the Department of the Interior to contain the escalation in contract support costs." In response to this directive, the IHS developed a "Report to Congress on Contract Support Cost Funding in Indian Self-Determination Contracts and Compacts". The findings of the report, based on analysis of tribal indirect cost rates, indicated that rates have remained relatively stable and have not unreasonably escalated. The report further indicated that the continued increase in contract support cost need is due primarily to the increased assumption by tribes of new programs, services, functions and activities from the IHS. The Office of the Inspector General within the Department of Interior reached a similar conclusion as a result of an analysis it conducted of a sample of tribes over an eight-year period.

In FY 1999, the IHS received a $35 million increase for CSC. Recommendations from the tribal consultation process resulted in the adoption of an allocation methodology that distributed CSC to those tribes with the greatest overall CSC need. The distribution of the $35 million increase in this manner resulted in the IHS being able to fund contracting/compacting tribes at an average level of 86 percent for CSC. No tribe in the IHS system was funded at less than 80 percent of its CSC costs at the time the $35 million was allocated.

Consultation with tribes also resulted in the adoption of a new policy in FY 2000 to govern the administration of CSC in the IHS. The policy implements a new process and methodology for distributing CSC within available resources to tribes for new assumptions of programs, functions, services and activities. The policy also implements a process and methodology for reducing the inequity in CSC funding for existing contract and compact tribes.

In FY 2000, the IHS received a $25 million increase for CSC. The same allocation methodology used in FY 1999 was used in FY 2000 to allocate this increase. The continuation of distribution of the $25 million increase in this manner resulted in the IHS being able to fund contracting/compacting tribes at an average level of 94 percent for CSC. No tribe in the IHS System was funded at less than 90 percent of its CSC costs at the time the $25 million was allocated. This is an increase of 8 percent in the average level funded and a 10 percent increase over the minimum funding level from the previous year. This increase in the level funded and the increase in the minimum funding level is a direct result of the IHS working with Tribes to contain ongoing program contract support costs and the promotion of consistency throughout the IHS system in the types of CSC awarded by the Agency for new and expanded programs.

In FY 2001, the IHS received a $19.453 million increase for CSC. The same allocation methodology used in FY 1999 and FY 2000 was used in FY 2000 to allocate this increase. The continuation of distribution of the $19.453 million increase in this manner resulted in the IHS being able to fund contracting/compacting tribes at an average level of 95 percent for CSC. This is an increase of 1 percent in the average level from the previous year. This increase in the level funded is a direct result of the IHS continuing to work with Tribes to contain ongoing program contract support costs and the promotion of consistency throughout the IHS system in the types of CSC awarded by the Agency for new and expanded programs.

Following are the funding levels for the last 5 fiscal years:

Year	Funding	FTE
1998	$168,702,000	--
1999	$203,781,000	--
2000	$228,781,000	--
2001	$248,234,000	--
2002	$268,234,000	--

RATIONALE FOR BUDGET REQUEST

Total Request -- The request of $270,734,000 is an increase of $2,500,000 over the FY 2002 enacted level of $268,234,000. The increase is as follows:

Contract Support Cost for New and Expanded Contracts: +$2,500,000

The $2,500,000 is for the increased contract support costs of anticipated new and expanded programs.

ACTIVITY/MECHANISMS BUDGET SUMMARY
Department of Health and Human Services
Indian Health Services - 75-0390-0-1-551
Public and Private Collections

Program Authorization:

Program authorized by Economy Act of 31 U.S.C. 686 Section 301-P.L. 94-437, Title IV of Indian Health Care Improvement Act.

Collections	2001 Actual	2002 Appropriation	2003 Estimate	Increase Or Decrease
Medicare	$107,742,000	$128,790,000	$128,790,000	$0
Tribal Medicare	6,986,000	6,986,000	6,986,000	0
Medicaid	293,896,000	302,032,000	302,032,000	0
Tribal Medicaid	22,217,000	22,217,000	22,217,000	0
Subtotal	$430,841,000	$460,025,000	$460,025,000	$0
Private Ins.	39,960,000	39,960,000	39,960,000	0
Current Law BA	$470,801,000	$499,985,000	$499,985,000	$0
Accrued Cost 1/	7,736,000	8,277,000	8,857,000	+580,000
Proposed Law BA	$478,537,000	$508,262,000	$508,842,000	$580,000
FTE	3,339	3,339	3,339	0

Reimbursable Obligation:	2001 Actual	2002 Appropriation	2003 Estimate	Increase Or Decrease
Personnel Benefits & Compensation	$202,048,000	$214,016,000	$214,016,000	$0
Travel & Trans.	4,181,000	4,398,000	4,398,000	0
Trans. Of Things	1,217,000	1,258,000	1,258,000	0
Comm./Util./Rents	4,106,000	4,218,000	4,218,000	0
Printing & Repro.	192,000	199,000	199,000	0
Other Contractual Services	78,889,000	81,616,000	81,616,000	0
Supplies	64,771,000	67,396,000	67,396,000	0
Equipment	6,922,000	7,175,000	7,175,000	0
Land & Structures	893,000	893,000	893,000	0
Grants	107,469,000	118,683,000	118,683,000	0
Insur./Indemnities	82,000	99,000	99,000	0
Interest/Dividends	34,000	34,000	34,000	0
Current Law BA	$470,801,000	$499,985,000	$499,985,000	$0
Accrued Cost 1/	7,736,000	8,277,000	8,857,000	+580,000
Proposed Law BA	$478,537,000	$508,262,000	$508,842,000	$580,000

1/ Please see Exhibit S for the crosswalk from current law to proposed law to reflect the Administration's proposal for full accrued retirement and health benefits.

PURPOSE AND METHOD OF OPERATION

MEDICARE/MEDICAID

The FY 2001 and FY 2002 Medicare/Medicaid (M/M) estimates reflect the CY 2001 rate. Tribal collections are an estimate Based on historical data

because there are no requirements for Tribes operating their own facilities to report this data to IHS.

The FY 2003 President's Budget assumes that the current 2002 rates will continue into CY 2002. Future IHS rate adjustments and projections will be following analysis of the FY 2000 hospital cost reports which will be completed this winter.

In 2002 and 2003, the IHS will continue to focus on strengthening business office management practices including provider documentation training, procedural coding, processing claims and information systems improvements. In FY 2000, IHS wide efforts were initiated to improve each hospital's capability to identify patients who are eligible or may become eligible for third party reimbursement. A major part of this activity includes the identification of all children who may be eligible for participation in the Children's Health Insurance Program (CHIP). For 2002 and 2003, the IHS will continue working with CMS and the State Medicaid Offices to help ensure the success of this effort. Other business management practices in progress, including automating Medicare and Medicaid billings and collections will assist IHS in its efforts to increase collections.

The use of the M/M reimbursements will be in accordance with approved JCAHO/CMS survey plans of correction and with identified maintenance and repair projects. The IHS will continue to place the highest priority on maintaining JCAHO accreditation standards for its health facilities. Specific Service Unit plans will be developed to respond to these projects. These include projects on IHS' backlog of essential maintenance and repair list that effects JCAHO/CMS standards, including health and safety.

PRIVATE THIRD PARTY COLLECTIONS

In FY 2002, private insurance collections have remained relatively stable due to managed care payment limitations and small numbers of our patients actually having private insurance. During FY 2002 and in FY 2003, IHS will continue its efforts to improve each health facility's capability to identify patients who have private insurance coverage and claims processing to increase private insurance billings and collections. Funds collected will be used by the local Service Units to improve services, including the purchase of medical supplies and equipment, and to improve local service unit's business management practice.

ACCOMPLISHMENT

For 2001, IHS, in collaboration with CMS, continues to improve its cost reports to base 2002 Medicare and Medicaid rates. Business office improvements included training on certified procedural coding of professional services using industry standards, patient benefits access, and accounts receivable follow-up. The IHS continues to improve its information system to process claims electronically and auto post payments in the accounts receivable system. For 2002, IHS plans to improve the processing of claims and a rewrite of its third party billing package to make it HIPAA compliant and to process claims under the new Medicare authority to bill Part B, the professional services component.

Accrued Retirement and Health Benefits Costs: +$580,000

The increase of $580,000 is associated with the proposed Managerial Flexibility Act of 2001; the full accrued cost in FY 2003 for Public and Private Collection is $8,857,000. This legislation requires agencies,

beginning in FY 2003, to pay the full Government share of the accruing cost of retirement for current CSRS, CIA and Foreign Service employees, and the Coast Guard, Public Health Service and NOAA Commissioned Corps. The legislation also requires agencies to the pay full accruing cost of post-retirement health benefits for current civilian employees. The intention of the legislation is to budget and present the full costs of Federal employees in the accounts and programs where they are employed. This legislation is part of an initiative to link budget and management decisions to performance by showing the full cost of each year's program operations together with the output produced that year. These accrual costs are shown comparably in FY 2001 and FY 2002.

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